April 1959

Mental Hospitals

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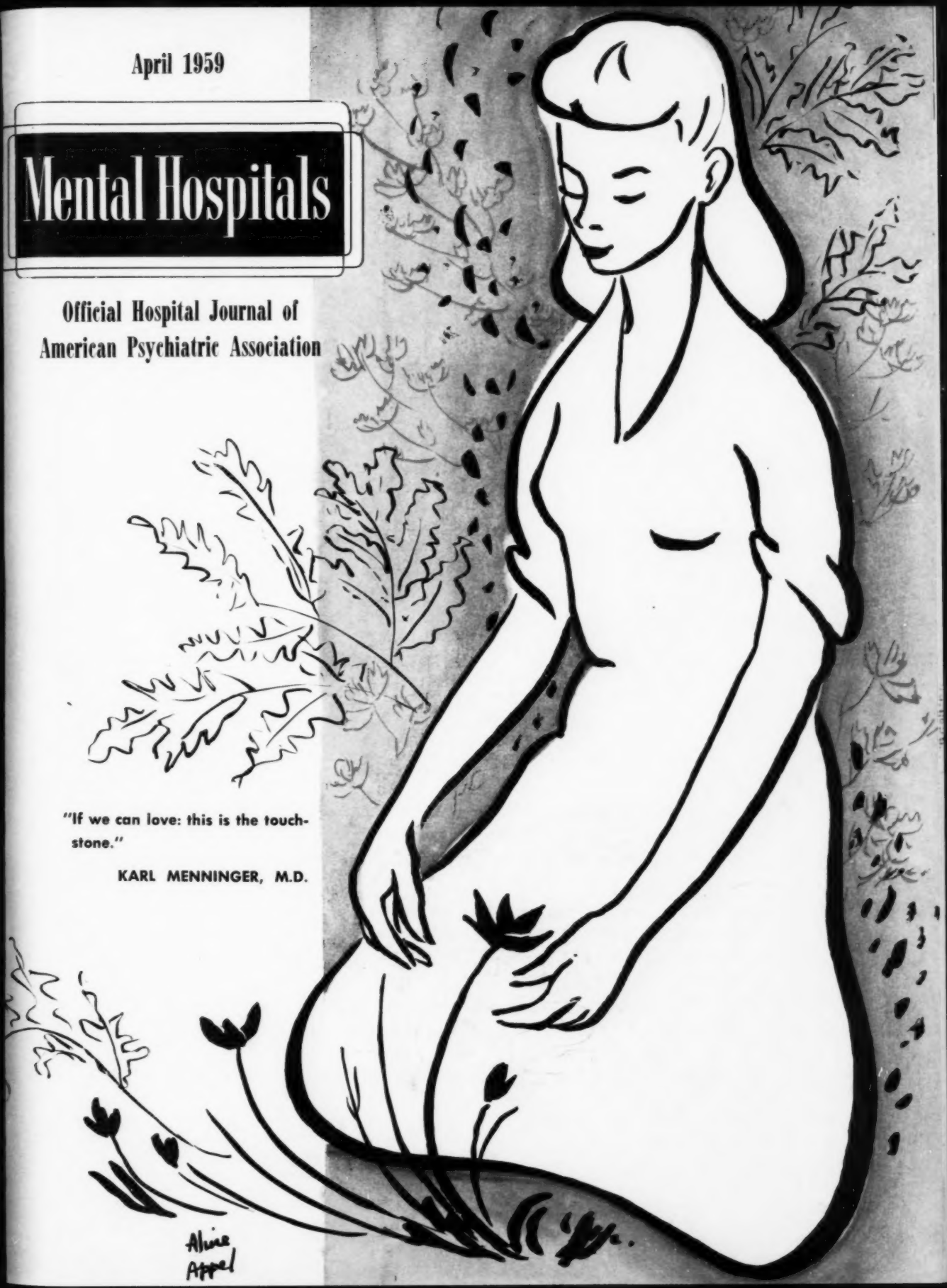

"If we can love: this is the touchstone."

KARL MENNINGER, M.D.

Mental Hospitals

VOLUME 10 NUMBER 4

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This Month's Cover

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1. Grossman, L.: *Archives of Pediatrics, 71: 173—179, June 1954.*

ANOTHER FINE PEDIATRIC SPECIALTY BY BREON

A New Community Mental Health Program In Eastern Kentucky

By RAY H. HAYES, M.D.
District Psychiatrist, Community Services, Department of Mental Health, and Director, Lexington Mental Health Center, Kentucky

IN JULY 1957 Eastern State Hospital in Lexington, Kentucky, in cooperation with the State Division of Community Services, initiated a mental health program, to offer for the first time diagnostic and follow-up facilities to the isolated, agricultural and mountainous communities as well as to the urban areas of eastern Kentucky. Permanent and mobile mental health centers were set up to provide communities with:

(1) Follow-up service for patients discharged from the state hospital.

(2) Limited diagnostic and treatment services, coupled with inservice training of teachers, public health personnel, and welfare workers.

(3) A public education program designed to foster constructive attitudes toward the mentally ill, and to develop an understanding of the benefits of mental health to the community as a whole.

By making these services available to even the remotest communities, the state effects a concomitant saving in dollars and cents, since it is, of course, far less costly to administer psychiatric care to non-hospitalized than to hospitalized patients.

Scope of the Program

The Eastern State Hospital District, with a population of approximately one million, embraces thirty-nine counties in the northeastern section of Kentucky and includes urban manufacturing centers, semi-urban mining communities, and small-farm rural areas. The district is served by the Eastern State Hospital with slightly over 1700 beds and by five outpatient mental health centers operated under the direction of the district psychiatrist by the Division of Community Services in cooperation with the state hospital. Two of the health centers are in continuous operation and three are part time; of the latter, two are mobile traveling units. At present the clinic staff consists of the district psychiatrist, a psychiatric social worker, a psychiatric consultant, a psychological consultant, and a secretary. In addition, the state hospital furnishes a physician, psychologist, and psychiatric social worker for the traveling team.

The first phase of the program began with an economic, social, and medical survey of the communities to be served. Economic conditions, educational, judicial, law-enforcement, and welfare facilities have been investigated. Local customs and prevailing attitudes towards mental health problems have been explored. Leaders of civic organizations and of public agencies have been interviewed, and over 1200 persons have filled out a questionnaire that provides valuable information concerning local attitudes toward mental illness. School children of the ninth and twelfth grades have also been interviewed. This exploratory phase of the program, conducted by Mr. Leonard Morgan of the Eastern State Hospital staff, is scheduled to continue for three years and will undoubtedly be helpful in measuring the extent to which the program alters prevailing attitudes toward problems of mental health.

From the initial survey it was evident that an approach based simply on familiarizing the public with the clinical entities and symptoms of mental illness would only frighten and confuse laymen and possibly arouse in some a morbid curiosity. (In this respect the laity is quite similar to the freshman or sophomore medical student who freely appropriates signs and symptoms he discovers in his pathology textbook.) Instead, we adopted an approach based on familiarizing the public with the characteristics by which optimal mental health could be recognized. We defined optimal mental health as:

1. An ability to accept, respect, like and forgive oneself.

2. An ability to accept fundamental differences in others.

3. An ability to cope sensibly and appropriately with everyday problems.

Because these criteria were not beyond the understanding of the public, they were helpful in creating rapport between the personnel involved in carrying out the program and the public to whom the program was brought. The people recognized that we were interested not only in the problems of a few disturbed persons, but in the over-all mental health problems of the community.

We also learned from our exploratory survey that we could not go as missionaries who had a program to impose upon the needy. Too many well-meaning persons and agencies have failed in their mission by taking the attitude: "We have come to help you! We don't like you the way you are! We are going to change you!" Our approach has been, "We may be able to develop a mental health program in your community, if you agree that

such a program is necessary and desirable. What can you do to help us?"

This question was first directed, of course, to the local physicians. They are more knowledgeable in respect to the mental health problems of their communities than are other persons and usually have a significant number of patients whom they wish to refer to the clinics for diagnostic and consultative purposes. We also contacted local, private, and public agencies that had had some experience in dealing with certain aspects of mental health, particularly on a referral level. In almost every community there is at least one agency which has had contact with patients who have been discharged or temporarily released from the state hospital. Local agencies have usually had some contact also with persons who are in the custody of the county, circuit or juvenile courts and who might benefit by being referred to clinics. Such referrals are generally accompanied, at least on the first clinic visit, by professional, responsible persons connected with the referring agency. Among other things, this custom serves to personalize interest in the patient, and helps to point up the mutuality of concern and rapport between the clinic and the established community agencies.

The Community and the Discharged Patient

One of the most serious problems to be faced by the patient who returns to his community is the attitude of his family to his illness. Frequently, the family refuses to accept the discharged patient. It is not at all unusual to hear family members expressing their rejection of the patient in terms such as these: "I'm afraid of him, he acts crazy!" Or, "I won't live with a crazy person; she's been in the asylum!" These comments often arise after an initial acceptance of the patient, although they do not necessarily occur as the result of the patient's behavior *per se*. They may be occasioned by the family's and community's deep-rooted prejudices and beliefs, or by peripheral economic, familial or social problems.

The role of the clinic, the local physician, and the established agencies in bringing about a more constructive and humane attitude cannot be minimized. However, we believe it is of vital importance to begin in the hospital the education of the patient along the lines of conduct he must follow on discharge if he is to remain in his community as an outpatient. For that reason our hospitals are currently being refashioned as "therapeutic communities" in which an attempt is made to familiarize patients with problems they will face in the particular communities to which they will be discharged.

Approximately 75% of all patients released from Eastern State Hospital are now participating in the medical follow-up program. On release from the hospital the patient is referred to his family physician or personal psychiatrist or to the mental health center nearest his home. Every effort is made to also use state hospital personnel in following up discharged patients, since we believe it is meaningful to the patient to be supervised in his post-hospital treatment by persons who have participated in his successful treatment while in the hospital.

The Department of Mental Health provides medication at full cost or at no cost to the patient, depending upon the degree of indigency. To be eligible to receive medication in this way, the patient must have been seen by his own or a departmental physician and the doctor's certification must have been forwarded to the hospital. The maximum time allowed between contacts is two months. Generally, a month's supply of medication is dispensed. The prescription is renewed once, with the understanding that the patient will remain under a physician's care. The second renewal is withheld until the hospital has confirmation that the patient is receiving medical care.

Our clinics take the attitude that the patient who has been discharged from the state hospital is essentially a healthy, normal person who has unfortunately chosen unsuccessful methods for dealing with interpersonal situations. He is mistakenly suspicious of and hostile to his fellow man. He fears that he will be hurt or criticized: he is afraid of social censure; and he constantly attempts to protect himself from disapproval. Our therapists, too, strive always to emphasize and utilize the positive aspects of the patient's mental and emotional condition. We have found that when this is done sincerely, the patient perceives himself as strong, worthwhile, healthy, and worthy of self-respect. To be completely effective, however, our philosophy must be shared by other persons and agencies of the community. Fortunately, we have had some success in obtaining such agreement. We can report, for example, that post-hospitalized mental patients are now being regularly employed by I.B.M. in

Remotivation in Kentucky

When a Remotivation Training Team from the Philadelphia State Hospital conducted its course for psychiatric aides at the Central State Hospital in Lakeland, Kentucky, class members gained practical experience working with patients. Above, a student encourages a patient to take part in group conversation centered around a flower picture. Instruction in the Remotivation technique consists of lectures, demonstrations and practice. Team visits are made possible by a grant from the Smith Kline and French Foundation.

Lexington and that the Eastern State Hospital receives an increasing number of requests for more patients for home placement.

During the past year, the clinics have handled over five hundred patients, not including collaterals. We have participated in some three thousand individual interviews and almost a hundred group interviews, and have conducted public events and activities requiring close to a thousand hours of preparation, travel and work.

Our chief treatment problem has been in devising ways to handle large numbers of patients, as this description of a typical clinic day will show. At Jackson, Breathitt County, we noticed that regardless of the time for which an appointment had been made, the patients were usually there at 8 a.m. together with members of the family and sometimes a neighbor as well. Taking advantage of the presence of these early comers and their families and friends, the district psychiatrist gave them brief talks, showed a movie on mental health, and conducted a discussion. Following this discussion, the patients who had attended the clinic before were taken into a group therapy session for an hour. New patients were seen either separately or with a simultaneous interview technique. Children were seen individually for consultation and diagnosis. Adult groups consisted of two to six persons, unless special examination was required. All new patients were screened for background by the psychiatric social worker before entering a group. By this method, a clinic of 19 to 30 persons, including collaterals, may be handled in the space of three hours. The therapeutic carry-over, with prescribed medication, is usually sufficient to maintain most patients between clinic sessions.

Educational Activities

In the afternoons we conducted seminars on mental health problems in the form of case discussions for teachers and public welfare workers. We placed particular emphasis on enrolling teachers in this seminar because of their vital influence on children. The mental health nursing consultant and the district psychiatrist have also taught semester-length courses for which student teachers obtain three college credits at Lee's College in Jackson or Eastern State College in Richmond, and have conducted a three-week, three-credit graduate workshop at Morehead State Teachers College. At present Pikesville College offers a mental health course for the winter quarter. At the pre-college level a mental health program is being conducted for the 7th and the 10th grades at Elkhorn City and Phelps Schools in Pike County. This program will consist of group discussion meetings with pupils and separately with teachers.

In July, a two-day mental health institute was held at Jackson for the local workers of the Division of Public Assistance, an important case-finding facility.

Regular consultation and inservice conferences are held for public health nurses. In September, Eastern State Hospital began a series of one-week orientation workshops for all public health nurses in the district who wish to participate.

Other educational activities have included a series of lectures at Asbury Theological Seminary in Wilmore and at the College of the Bible in Lexington. In October the district psychiatrist began a one-year Laboratory in Interpersonal Relations for students of the latter school. In addition we have offered training to three psychologists who were doctorate candidates, one psychiatric resident from the U.S. Public Health Service Hospital, and a minister from the College of the Bible.

Research and Evaluation

In order to meet the great load of work, self-study projects have been undertaken to evaluate effectiveness and to develop the most efficient ways of handling large numbers of persons. Some investigations include the following areas:

(1) Evaluation of the effectiveness of the program as measured by changes in public attitudes toward mental health.

(2) Development of methods for handling large groups of patients with few personnel.

(3) Development of other case-finding agencies.

(4) Exploration of simultaneous interview techniques for solving diagnostic problems.

(5) The use of lay counsellors with delinquents.

(6) Evaluation of the efficiency of various medications in outpatient settings.

(7) Evaluation of the effectiveness of psychopharmacological therapy in the outpatient clinics to which a number of our patients return (part of a six-state study made possible by a grant from Smith Kline and French).

Mental Hospitals Material now Professionally Indexed

Our subscribers and authors will be gratified to learn that MENTAL HOSPITALS is now indexed in the Current List of Medical Literature, published monthly by the National Library of Medicine.

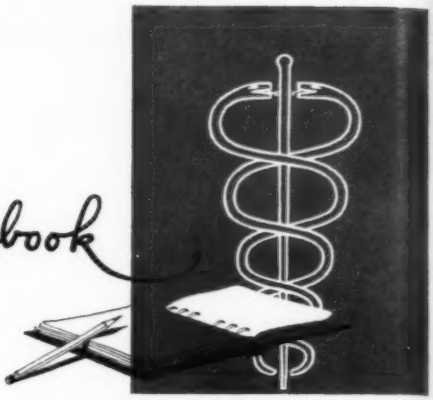
The Current List, which succeeded the Index Medicus, indexes all of the major medical publications of the entire world—over 1600 of them—and is to be found in practically all of the principal medical and institutional libraries of the world. (There are about 4500 subscribers.)

The inclusion of MENTAL HOSPITALS means that the journal has now "arrived." Each article will be indexed in the Current List, and will thus come to the attention of readers the world over who are interested in the various problems treated in its pages. Thus the usefulness of our magazine is substantially increased.

The Mental Hospital Service is grateful to the National Library of Medicine for this recognition.

WINFRED OVERHOLSER, M.D.
Chief Consultant, A.P.A. Mental Hospital Service

The Editor's Notebook



DR. HAYES' and Dr. Kirkpatrick's articles (pp. 9 & 16) on their community-centered mental health programs illustrate the nation-wide trend to disperse responsibility for the treatment and prevention of mental illness among broad segments of the community—general physicians, general hospitals, social agencies, the courts, mental health societies, public health and welfare agencies and all manner of groups that deal with human problems.

Less than a decade ago our slogans had to do with rescuing the large public mental hospitals from their sad plight. We begged for more beds, urged the construction of intensive treatment units, established personnel standards. We fostered the assumption that given the money, the personnel and the facilities we could make our hospitals into genuine treatment centers.

Today, to be sure, we are still fighting this battle, and indeed, we should be. But the emphasis has changed. Today it is upon alternatives to or modifications of hospitalization. We plead for open hospitals, day hospitals, night hospitals, clinics, half-way houses, rehabilitation centers, sheltered workshops, after-care programs, mental health centers and the like, many of which were almost unheard of in American psychiatry ten years ago.

Each one of these devices assumes a sharing of responsibility, since none of them can materialize without community backing, teamwork and cooperation. Whether we regard them as long-range alternatives which will ultimately lead to the demise of the mental hospital as we know it today, or whether we view them instead as sturdy reinforcements to the public mental hospital, we are all in agreement about one thing: these modifications or alternatives are immediately necessary.

The dispersal movement brings with it new and striking opportunities for effective psychiatric leadership, and also some threats to the psychiatrist as a physician. It seems to me that the opportunities are more exciting than the risks are alarming. A new *persona* of the psychiatrist is crystallizing for he is becoming in effect the "community trouble shooter," the expert, the man to whom the general physicians and the social agencies must look for leadership. It is incumbent upon us to give thoughtful attention to our role and integrity as physicians in this movement as it develops.

By this I mean that our primary consideration must be to muster all the usable resources of medicine to overcome the scourge of mental illness. Our first contact with the community should be with our medical colleagues, the family doctors. Congress has recognized the importance of this resource and has appropriated funds for the N.I.M.H. to allocate for the purpose of educating general practitioners in psychiatry. The expectation is that they will be able to do a better job of diagnosis, treatment and referral with their emotionally disturbed patients, and thus be able to give active leadership in support of community mental health programs. Our contribution here can be great.

We should focus our primary efforts on community programs and devices which most closely reflect the consensus of our own specialty and of medicine generally as to their soundness. While we must not divorce ourselves from the vast complex of social and community forces, we must maintain our conscious determination to let our obligations as physicians be our overwhelming consideration in relating to these forces.

If our colleagues in other branches of medicine are critical of us, it behooves us to correct our deficiencies. If the criticisms result from a lack of understanding, as they so often do, then it is for us to communicate. We must establish medical contacts and associations through seminars, curbstone conversations, medical society meetings, collaboration in hospital settings, professional journals and all other available means. There is no mystery about communication. All we need is the resolution to achieve it.

One would urge hospital psychiatrists to take the first step towards breaking down the isolation about which they so often complain. They should seek active participant membership in the local medical society, be available to give talks to appropriate community groups; donate a generous amount of time to clinics and other selected agencies, and above all, take the time and make the effort necessary to bring the "family doctors" into the picture.

These are some of the responsibilities we face. We know that psychiatry alone cannot do the job which confronts us, but to insure that psychiatry will assume its responsibility we must give the proper professional leadership.

Matthew Ross, M.D.

TOWARD SOCIAL PSYCHIATRY

"Cure" may be an unrealistic treatment goal for some patients. If so, a different type of continued treatment ward is needed.

By ADOLF HAAS, M.D.

Assistant Chief, Female Service
Ypsilanti State Hospital, Michigan

THE PATIENT in the average public mental institution should be considered from the point of view of his environment, which is created by the institution to whose physical and dynamic laws he is subject. Such institutions, bearing the name of hospital, were ostensibly created to return a patient in due time to the community. In too many cases, however, they have failed in the past to do so. To a large, possibly major portion of the patient population, therefore, a mental institution is not a hospital, but a place in which to live for many years, perhaps for life. To the outside community a mental hospital is a place which is thought of with a certain shiver, a place in which to keep people who make the streets of the average community unsafe or uncomfortable.

More specifically, therefore, we would like to consider a patient on whom all the ministrations and treatments provided by the hospital have failed, and who has therefore ended up on the "back wards." One is tempted to think, at times, that this patient ended up there because of, rather than in spite of, such ministrations and therapies! This is not such a blasphemous thought as one might assume. Medical nonsense fills many pages in the history of our art. It is often tragic and almost always humiliating. One needs only to think of the abuses of blood letting, of the murderous treatment with antimony derivatives and many other universally accepted medical practices of the past. And how long ago is it since schizophrenics were treated with colonic flushings or barefoot tramplings on the dawn's dew? Nor should we forget that some highly esteemed physicians of those times defended such therapies to the last drop of their patients' blood. Those times are uncomfortably close indeed.

Sociocultural Problems of Large Hospitals

It is still true that the majority of those in need of long-term treatment for mental illness have to make use of large, publicly-supported institutions. In spite of the growing number of admissions to the psychiatric units of general hospitals, a handful of worthwhile private hospitals, and the private practice of psychiatry, prolonged treatment is available only in the public hospitals. At least half of these patients will spend many years in a public institution, either continuously or cumulatively. The number of older patients admitted is increasing as a result of better medical care and thus increased life expectancy, and of the increasing unwillingness of their relatives to keep them in the community. Soon more than half of all the patients in state institutions will be geriatric patients, who will as a rule spend all their declining years there.

One can easily see, therefore, that besides dealing with individual diseases, large mental hospitals are involved in a socio-cultural problem. One can seriously bemoan the fact that so little use has been made, up to now, of the accumulated knowledge in the fields of social psychology, anthropology and sociology. At times there is evidence that very little use is made, indeed, of common sense!

The general hospital of today carries the connotation of a place where one is treated rapidly, a place of essentially short-term hope for comfort and recovery, or death. On the other hand the connotation of the large mental institution is, for the relatives, relief from the immediate pressures of the problem, but for the patient, an indefinite custody with no firm hope of eventual recovery and release. There is, therefore, a social function of tremendous magnitude and scope for such an institution to perform.

Mental Hospitals Should Protect Patients

The mental hospital should, in itself, become a remedy, a therapeutician. It should protect the patient from abuse, from ridicule and from undue stress. A society, be it a community of patients, or a country, seems to have certain basic dynamic laws which operate in a sovereign manner, and cannot be either guessed at or ignored. Of the basic laws which operate in the specialized community which is the mental hospital, we psychiatrists seem to be pitifully ignorant.

It is possible that we have tried too hard to transfer the experiences of the individual psychiatric approach to the management of the hospitalized psychiatric patient. Certainly our attempts to create an environment called "the therapeutic milieu" have been experiments with unknown factors. While the gifted physician does the right thing more often than the less gifted one, both are groping in the dark of an unknown and uncharted world, assuming, like the drawing room "do-gooder," that good will and charity are all we need to lead human society—and incidentally the mental hospital society—to its glory and happiness.

Let us then consider the mental institution as primarily a social structure of which the boundaries and physical structuring elements are predetermined. These physical limitations have been devised by architects, engineers

and diverse advisers who are for the most part amateurs in the field of social knowledge. The population of the hospital community is also predetermined, although the selection is a more natural one. The patients come from all the crossroads of life, having one thing in common: failure. On the other side of the hospital community are the people who invest one-third of their daily living time there, the employees. They too bring certain attitudes of motivation and of social class into the picture. Their selection seems to be less uniform than that of the patients, but more diversified as compared to the rigidly predetermined physical structure.

Ward Community Invites Research

From the schematic description of this specific community, therefore, it appears that we deal with a structure of which the components are perfectly well describable, but whose dynamic interactions are virtually unknown. In its *per se* structure, the mental institution presents the researcher with conditions closely resembling those prevailing in primitive societies, and therefore well suited for social and anthropological studies. The "continued treatment" wards especially, much more closely resemble an isolated community than they do a hospital, and are in particular need of our scientifically supported human attention. Since there is apparently no possibility of individually designed care for the inhabitants of these long-term wards, we could at least study such ward communities so intensively that coming generations of patients who will have to live out their lives on such wards can do it in a more satisfying and dignified manner.

In order to move toward this goal, we will have to abandon many a dream of pharmaco-magical glory. We must consider only the things of which life essentially consists. These are not expensive medicines or magic formulas. Life consists of an unending array of small, seemingly unimportant events, feelings, things. To remove chains is not enough to give people freedom. To open more and more wards is not enough. These things help and they point the way. In essence they help only because they are in accordance with a basic social law which reads something like this: "Individuals or groups of individuals who are treated as 'different' become as a rule behaviorally deviant." This deviation seems roughly parallel to the premises of the original approach.

There are now common in mental institutions many examples of practices, the laws of which could profitably be studied. The creation of cafeterias may be used as an example. As little as one may think personally of cafeterias, in mental institutions they constituted a big step towards progress. Many a patient who otherwise never left his ward suddenly found interest in meeting and being met by others. Across a dreary, slow-moving "chow line" there began to flicker a spark of long forgotten social interest, and some social graces were revived, no matter how rudimentary. One might argue that our social graces form only a thin cover of varnish incompletely disguising a savage, but what we are, to a great extent, is the difference between varnish and no varnish!

It is obvious to us all that the relationships between all the personnel involved in the treatment of mental patients in an institution are of paramount importance. If such relationships are free of tensions, patients improve more rapidly and become more comfortable. Many factors are involved in the creation of such relationships, but on the whole, they develop by pure chance. There might be, however, some basic laws which, if followed, would permit the creation of desirable relationships with more than a haphazard chance of success. Such laws will, of course, always be aided by the personality factors of the key personnel involved. But by applying certain basic premises, it might be possible to create teams of workers which would function better than average, independent of the special talent now required of key personnel. Perhaps we should start by organizing all the personnel into closely-knit ideological groups, which would have to be trained equally well to bear both success and defeat. In a sense such groups of people should form a firm and yet flexible body, which in its operation would resemble the functions of a healthy ego in an individual. Free criticism and free exchange of knowledge among all the members of the group would be an absolute prerequisite of its functioning. The groups would have to be trained to be able to absorb new individuals and also to lose old ones with unremarkable and only temporary loss of effectiveness. To achieve this goal, we need to know the laws which govern the impact of individuals on groups which are both closely knit and capable of unprejudiced approach to reality. In short, we must find out how to perpetuate a given social form in a purposeful, meaningful fashion, and at the same time, how to guard against stagnation of both form and content. These things are, of course, not our only problems, but we feel that they are vital to us, and that we have a setting almost ideally suited to research and experimentation along these lines.

Discharge May Not Be Primary Consideration

Another possibility is a change in the physical environment of the "continued treatment" wards. But before any experimentation along these lines could be conducted, a change in the goal-orientation of the average hospital psychiatrist appears mandatory. First of all, he would have to accept the idea that the eventual discharge of the majority of the "continued treatment" patients will never, and perhaps should never, be the primary consideration. One might even go further, and say that to burden these people with the goal of discharge is unfair both to them and to the community. Thus this treatment goal is ineffective and may even be unethical if it causes patients unnecessary suffering. Why should we torment them with our own guilt which arises from an illusory feeling of failure? The failure, if it exists, has its roots in the refusal to face the reality that a certain percentage of mankind will become and will remain permanent social failures for no matter what reason. (By the same token, a certain percentage will also be unusually successful, following the natural distribution curve of any set of factors in a large enough sample.) If we face this fact, and take our tasks from there, we will have a different, more realistic approach

to the problem of the chronic patients. Nor does such acceptance take psychiatry out of the realm of medicine, for as Dr. E. L. Trudeau said, "To cure sometimes, to relieve often, to comfort always." •

To return to the possible changes upon the physical environment which would result from this acceptance, one can visualize wards which would be built like apartment houses. People could live there in circumstances closely resembling the conditions considered desirable in our particular culture. Just as children gravitate to toys which help them to prepare for and identify with their future roles, our patients need the "toys" of adult culture to remove their oppressive sense of failure and to feel that they truly "belong" to the human race. A trained and cohesive staff would supervise and help to create the feeling that the patients are being treated inside and not outside of our own society. Small groups of patients could live self-sufficiently and perhaps adopt and motivate more regressed ones. If some small industry could be created within this microcosm of society, the feeling of socially acceptable worthiness would be increased. Patients could enjoy a certain privacy which they so painfully lack on our cavernous wards of today. They could, to some extent, forget and forgive the humiliation which goes with entering any institution. We would no longer be robbing them of the little things which make us human. Were we "healthy ones" forced to live within their existing limitations, we would probably scream bloody murder. They do not do this. Instead, they regress still more.

Perhaps we cannot cure all our patients. But we could, if we worked on the problem, create for them a little more socially correct and humanly decent situation which would accomplish a good deal. We could perhaps discover a more sound socio-psychiatric basis for mental health, thus reducing the number of those who must spend the rest of their lives in mental institutions. Above all, we could enable our patients to recapture the feeling that they are human, that they are still alive, and that life, even in the mental institution, is not altogether without hope, without pleasure, without even a measure of happiness and dignity.

•On bronze plaque commemorating Dr. E. L. Trudeau at Saranac, N.Y. See also Stephen Chalmers "The Beloved Physician" (Boston 1916).

Are We Free Loaders?

By DR. WHATSISNAME

OUR HOSPITAL is in a rural area, at the edge of a tiny township. It's a single general-store town. We do most of our marketing at the hospital commissary and our wives go to a nearby little town over the county line for their more serious shopping. Although the hospital has a large payroll, practically none of it sticks in the little town. Still, our children go to their schools.

Last night I went to an open meeting of the Board of Education. The question was whether to adopt a report favoring higher teachers' salaries, a kindergarten program and other improvements. I was in favor of it, and if I had been a taxpayer I would have been willing to pay the higher taxes. But I found myself silenced by the fact that I paid no taxes. Sure, I could urge the Town Fathers to raise taxes. It wouldn't hurt me. I lived on the hospital grounds, so my rent money went directly to the State government. My children were a burden on the township's taxpayers. Our occasional eloper was a burden on their police. Visitors to our hospital jammed the township roads and made frequent repaving necessary.

In some states, the state hospital is on a reservation with special provisions for schooling, sewage and traffic control. VA hospitals are on federal reservations—which brings community public relations problems of a different sort. Occasionally state hospital personnel live in a nearby town and pay taxes or rent.

For most state hospitals though, the problem remains unsolved. Hospital personnel living on the grounds generally use the commissary for daily marketing and an out-of-town shopping center for weekly marketing. They shop for their heavier needs in a city. They pay no taxes or rents. Yet they have a stake in the many tiny towns, boroughs or townships in which our state hospitals are located. If they try to exercise their franchise by speaking at township meetings or signing petitions, they are branded as free loaders on the township.

There must be an answer to that criticism. Only I can't find it.

A DUAL-PURPOSE TREATMENT CENTER

A Combination Day Hospital and Outpatient Clinic Serves Community Needs

By WILLIAM L. KIRKPATRICK, M.D.
Director, The Lafayette Mental Health Treatment Center, Louisiana

THE LAFAYETTE MENTAL HEALTH TREATMENT CENTER was opened in August of 1955. It functions as a day hospital and outpatient clinic for the Central Louisiana State Hospital, which is under the direction of Dr. Arthur L. Seale, but the center is located at Lafayette, one hundred miles away from the parent hospital. Structurally it is part of the Lafayette Charity Hospital, a one-hundred-and-fourteen-bed general hospital operated by the State Department of Hospitals.

The formula for the treatment center was taken from the Survey and Planning Committee on Mental Health Needs for Louisiana, of which Dr. Daniel Blain, then medical director of the A.P.A., was the chairman. It was originally set up as a pilot project to run from July 1954 through July 1956 but, with the amount of preliminary planning and organizing involved, did not begin its actual operation until the second year of the projected period. Now, after three and a half years, we feel that the treatment center has successfully demonstrated its value to the community and more than justified its continued operation. It is now possible to offer some evaluation of our activities for the benefit of other states which may be contemplating the establishment of similar facilities.

Originally Housed in Ambulance Shelter

Originally the center was set up in an old ambulance shelter which was vacated by Charity Hospital, and which was renovated to accommodate the mental health center. A few months ago the center was granted the temporary use of a five thousand square foot ward, which will be used for a contagious disease unit when the center moves to permanent quarters.

Currently a group of interested, civic-minded people in the community have formed an organization known as the Southwest Louisiana Mental Health Center, Inc. Its primary purpose is to study means of obtaining permanent quarters for the center. This group has already raised $30,000 and has purchased a site for the new structure.

The treatment center operates eight hours a day, five days a week, and handles approximately five hundred newly-admitted or re-admitted cases each year. The staff sees as many as sixty patients and gives as many as thirty electroshock treatments in one day. The policy of the center is to treat people who otherwise would be candidates for the mental hospital. This, for the most part, limits our patients to adults. However, we do at times treat children and adolescents, when the case warrants, although less than fifteen per cent of our patients are under twenty-five years of age.

Psychological tests are given when indicated. Above: psychologist administers a Rorschach test to a patient

Our present personnel consists of two part-time consulting psychiatrists, a psychologist who also serves as an administrator, a part-time consulting psychologist, two institution counselors, one graduate nurse, three practical nurses, two stenographers, and one maintenance worker. Some of the employees speak French fluently, which is necessary because thirty percent of the patients speak only French.

Patients are accepted for treatment by appointment only, except in emergencies. Private physicians refer approximately forty-two per cent of the case load, and seventeen per cent are referred by Lafayette Charity Hospital. Other referrals come from such agencies as the Evangeline Area Guidance Center (an outpatient clinic in Lafayette), the Department of Public Welfare, the Coroner's Court, the Public Health Unit, and other agencies which have physicians on their staffs.

Cases Must Be Appropriate to Day Hospital Care

Only cases which can be treated more expeditiously and economically in a day hospital are accepted. We are not set up to handle the violently disturbed, geriatric cases, those who require round-the-clock nursing care, have serious physical difficulties along with their mental illness, are bedridden, or are judged criminally insane. Neither are we able to accept patients who refuse or will not cooperate with psychiatric treatment.

In addition to the electroshock treatment mentioned above, our therapeutic regime includes carbon dioxide therapy, drug therapy, and psychotherapy. Physical and psychological tests are given when indicated. The psychologists give counseling under psychiatric supervision to those who require psychotherapy. Recreational and occupational therapy have been offered in the past but, because our staff is limited, this has been temporarily discontinued. In the near future we plan to re-establish such activities. The day room, however, offers a variety of recreational material which the patients may enjoy by themselves, with other patients or with their relatives.

Above: Knowledge of physical condition is gained through laboratory tests such as that illustrated above.

The average patient spends about four hours a day in the center, and later in his treatment is seen twice weekly until, with improvement, the interval between visits is increased. When the patient has shown almost complete remission he is seen once every three months. When sufficient improvement is indicated, the patient is discharged. If he does not improve, arrangements are made with the coroner of his parish to commit him to a mental hospital.

One aspect of our operation which deserves mention is the cooperation we enjoy with other agencies, both state and local. For example, Dr. O. P. Daly of the Lafayette Charity Hospital has made laboratory and maintenance services available to us and permits us to consult specialists on his staff. We in turn act as a psychiatric service to the hospital and get approximately seventeen per cent of our referrals from the hospital physicians.

Center Staff Available for Talks on Mental Health

Local groups such as the Altruso Club, Kiwanis Club, and Acadian Department of the Louisiana Association of Mental Health have donated magazines, books, cards, and have sponsored holiday treats. The Woman's Service League provides volunteer workers. We get assistance from Alcoholics Anonymous and the local clergy. In return, our staff is available to speak on mental health topics before community organizations.

One of the outstanding features of our operation is the extent to which relatives of the patients are interested in and even help in the treatment program. In fact, it is not unusual to encounter more relatives than patients in the unit, for it is customary in this area for several family members to accompany each patient. We feel that, instead of being in the way, the relatives are, for the most part, useful to have around. If a patient receives electroshock treatment, for instance, one or several members of his family will accompany him to the treatment room, and afterwards sit with him during the recovery period and get him the fruit juice or milk which is available to all patients after EST. After the patient has fully reacted, the relatives help him leave the treatment room. They also help with other patients whose family members are not present, assisting them in the same way as they assist their kin.

On a state level we work with the state mental hospital and with governmental agencies. The center gives follow-up treatment to state hospital patients who are on furlough or recently discharged. We also give emergency treatment to patients awaiting admittance to a state or VA hospital. The Department of Public Welfare has been extremely helpful and cooperative with reference to the needs of our patients. The State Department of Vocational Rehabilitation offers job training and placement to qualified patients.

The center has proved its need and its value to the community. Many professional people believe that this type of facility may be the answer to the overcrowding of our mental hospitals, because it reaches into the community and results in early treatment of the patient. We believe that the success of the center has eliminated the necessity for building a fourth mental hospital in the State of Louisiana.

THE WAY TO AN OLD MAN'S HEART . . . . .

ELIZABETH CADY, B.A.
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As part of the recently initiated "total push" or remotivation program for geriatric patients at our 950-bed neuropsychiatric hospital, the dietetic service has been conducting experimental classes for these patients. The "curriculum" has evolved on a trial-and-error basis and the "students" receive no credits, but the course is a success and the teachers are gratified.

Our first problem on being solicited to participate in the program was how to proceed with classes for these men with whom we had had very little contact except at meal times. The nursing service was unable to offer any specific suggestions as to course content, since the program was as new to them as it was to us. However, we were agreed that just getting the patients off the ward and talking with them would provide a unique experience for the patients and for the dietitian. Up until this time these men, most of whom have chronic brain syndromes with arteriosclerosis, had been relatively inactive during the vast majority of their waking hours. Three times a day they were escorted to and from the dining room in their ward building, but this was the extent of their activity.

Patients Grouped by Degree of Contact

Selection of the patients for participation in the over-all remotivation program was done in a very general way. The men were placed into one of seven groups depending on their individual degree of contact with their environment. The ward staff hoped that in this way the best oriented patients could benefit the most by greater activity.

The dietetics department was assigned one group of men in fair condition (Group 1), and one group of rather poorly oriented patients (Group 5). Group 1, which contained more than twenty men, was further broken down into two classes to permit individual participation.

Our main problem in this situation was our own lack of experience; that is, we had no idea as to the condition of the patients in the respective groups, the level at which to teach these groups, the method most likely to gain the best results, or the classification of material which would be of greatest interest and appropriate for the men. As an initial experiment we scheduled classes of one hour for each group every week. We knew the attention span of these patients was extremely short so we did not plan to use the whole hour, nor did we. Also, from previous experience with other patients, we decided that more than ten patients in a group would be ineffective. For the first few weeks we took various types of teaching material to each class. These materials included a Basic 7 Foods sheet, which could be explained and could be taken back to the ward by the patients; information about the origin of vegetables, which could be read to them; simple cardboard food models; and simple film strips pertaining to various phases of the dietetic service.

Initial Class Discouraging

The first meeting was certainly a unique experience! Discussion of the origin of vegetables was attempted with Group 5. There was only a vague response from two patients. The men were more interested in the new eating arrangement which had been set up for them in one of the main building cafeterias. So a brief description was given of what would be expected of them. (For instance, they would be carrying trays instead of just holding plates as they had been doing.) However, the burning question was, "When do we go back to the ward?" There were a great many patients talking to themselves, and one actually lay down on the floor and went to sleep. My first reaction was one of great futility.

The first meeting with ten men from Group 1 lasted for 30 minutes. The patients were in good contact with reality, and at the end of the period the instructor hated to close the discussion for they appeared to be enjoying the meeting. The men exchanged comments among themselves and the dietitian on the subject of fishing. The original topic was special diets and how they were prepared in the kitchen. Somehow the fishing conversation developed out of this. Needless to say, the results of this class were very encouraging.

The second meeting with Group 1 men was not as successful as it might have been. By mistake 18 patients were brought over at one time, but it was decided to make the best of the situation. Although the men were in fair contact with reality, it was impossible to keep them on one subject. Five men talked of their service life, and one told about cooking mixed vegetables on a camping trip, adding a squirrel's head for flavor. "Very good!" he said.

After several sessions with the groups, it was concluded that the best method for class participation was a discussion of the seven food categories followed by utilization of whatever knowledge the patients assimilated from using the food models. We discovered that attention span was longer when individual attention was given, and that

the men showed more interest when they used their hands. The majority of patients in Group 1 were able to set up a nutritionally desirable breakfast, lunch, and dinner after a talk on the Basic 7. They were very pleased by their accomplishments.

Short film strips were tried next, the audio being provided by records, but these elicited very little attention. In Group 5 when the lights went out the patients started talking to themselves or went to sleep. Their attention might have been better, however, if the audio had been louder. After several meetings with this group, it was discovered that a few of these men were totally deaf and one had not spoken in years.

A small booklet on the subject of keeping young and active after forty by eating well and thinking actively was read to the groups. Several of the patients later expressed their enjoyment of this booklet and one man said he had the same philosophy of feeling young and thinking young in order to stay young all his life. He said that some of the old men on the ward just sat around hating themselves and others all day long because they did not do a thing but sit. Apparently, this old man felt he was *on* the ward but not really *of* it.

Various sound movies, both black-and-white and colored, pertaining to the Basic 7 and to vitamins and their relationship to good health were also used as teaching aids. Group 5, as usual, paid little attention to these films after the lights had gone out. However, the rest of the men were attentive and response to discussion was fair. As was to be expected, the same men usually participated in the discussion each time. After several films had been shown, a "quiz" was given to determine just how much of the material had been absorbed. The men were told to hold up models of the foods that contained predominantly protein, carbohydrate, fat, or vitamins. Those foods containing protein, carbohydrate, or fat were the easiest for them to identify. Vitamins were more difficult. Group 5 gave virtually no response, but Group 1 got most of the answers either totally or partially correct.

Lastly we introduced as class material some food pictures clipped from magazines and cut up to make jigsaw puzzles. Response to this game was extremely good. All of the patients participated and did quite well although some needed a great deal of help. The most alert patients put together three of our puzzles with little trouble. It is impossible to determine exactly how much the apparently inattentive patients absorb for just when they seem least interested, these men make very pertinent and logical comments. Their backs may be turned or their eyes shut, but they are still in contact with reality.

Poorly Oriented Patients Show Minimum Progress

Group 5 showed little progress during the four months of classes. Nevertheless, the nursing aides reported that these patients automatically got up to leave the ward when class time was announced, whereas at first they were highly resistant to moves of any kind. Even this is advancement for such poorly oriented patients. Group 1, as expected, showed the greatest signs of improvement, and several of these men have been released to foster homes.

USES OF THE PAST

VIII. *English Quakers and Architecture*

THE QUAKERS in the area of York, England, were markedly distressed in 1790 when a young girl of their sect died mysteriously at the York Asylum for the Insane. William Tuke (1732-1822), a local Quaker merchant, made it his philanthropic duty to see that a new institution be formed not only to treat fellow Quakers who were insane, but also and more especially to initiate therapeutic methods different from those previously used. Tuke had long distrusted the medical approach and it was his Quaker heritage that contributed to the new primary emphasis on kindness and non-violence towards the insane, who would be accepted and treated as members of a large community family. The York Retreat, when founded in 1792, demonstrated even in its name its haven-like quality.

The design of the new brick building on the outskirts of York emphasized economy and convenience. It was substantially built and gave the pleasant appearance of a farm surrounded by gardens. Tuke studiously avoided a prison-like atmosphere by eliminating bars and shutters on the windows. Instead, window panes were set in cast-iron frames which were made to look like wooden ones. The windows, however, were placed high in most rooms in order to avoid breakage. Natural light predominated, with almost every room having its own window. There were enclosed courts to the rear of the building, but because of the declining ground even these did not appear too confining. There were no underground cells in this institution. The rooms were largely in the two wings coming off from a center building. The central portion was used for dayrooms, dining area, and special patients. There was separation of the patients by sex, degree of illness, and station in life.

The renown of the York Retreat was to spread gradually not only through England but also to the Continent and to the United States, where in later years it was to influence the planning of several institutions. It was to affect even more the type of therapy practiced in many hospitals.

The grandson of the founder (Samuel Tuke, 1784-1857) brought further fame to the hospital. Partly as a result of inquiries from the U.S., he published in 1813 his *Description of the Retreat,* which gave the history of the hospital, its organization and the method of therapy in use there. He emphasized that errors tended to occur in the design of such an institution because of excessive emphasis on safety although, in his opinion, cure and comfort were just as important. He pointed out that the York Retreat contained certain errors in construction: the outdoor courts were too small, the windows unnecessarily high, the noisy door bolts undesirable, and the corridors in the wings much too gloomy. In 1815, he submitted a prize-winning plan for the asylum to be built at Wakefield, England, and in 1841, wrote a long introduction to the translation of Dr. Maximilian Jacobi's work on hospital design.

ERIC T. CARLSON, M.D.

A Discussion

THE PSYCHIATRIC WARD ADMINISTRATOR

In the March issue of MENTAL HOSPITALS, we published an account of a deliberate attempt to divide the therapeutic and administrative roles of ward psychiatrists, in an attempt to create a therapeutic milieu. This account was written by a ward team at the Department of Psychiatry, University of Illinois, and the Editor solicited comments from several experienced psychiatric administrators.*

The replies were so thoughtfully presented that it has been decided to devote the space set aside for READERS' FORUM exclusively to this discussion. Other interesting letters to the Editor are being held over until next month.

A Clearly-Stated Theoretical Base is Lacking

THE PAPER by Drs. Chessick, Wasserman, Gerty and Miss Huels touches upon a topic of great personal interest to me. I am currently administrating the activities of the psychiatric ward at the Mount Sinai Hospital in New York City. I also give a course at Columbia University on "The Social Dynamics of Ward Management."

It has seemed to me that the behavior of the individual patient cannot be properly understood except in the context of the total ward situation. The ward, personnel and patients alike, constitutes a social unit and it is this social unit which I consider the therapeutic instrument of prime importance. The idea that "treatment" is a process which takes place during the hour (or fraction thereof) during which the psychotherapist is with his patient is implicit in the paper. At least, that is what seems implied in the phrase, "the other 23 hours of the patient's daily life" which recurs throughout the paper. At the risk of repeating platitudes I would like to emphasize that the total period of hospitalization should be structured, insofar as this is possible, to provide the patient with a continuously therapeutic experience. The application of somatic therapies in selected cases, recreation and occupational therapy, the help of social service, the controlled impact of visitors, the privilege of leaving the hospital on a pass, the use of the telephone, mealtime experiences, bedtime, getting-up time—in short, all the things that happen around the clock—should be regarded as vital details in a unitary therapeutic process.

This point of view is incompatible with the notion that there are *administrative* problems with individual patients as contrasted to psychotherapeutic problems. Administrative decisions require a detailed knowledge of the social dynamics of the whole ward, as well as the psychodynamics of the individual patient. Proper administrative decisions are therapeutic interventions which provide corrective emotional experiences for the individual patient. These decisions presuppose the existence of proper techniques for the collection and exchange of information, as well as a scientific theory of human behavior in terms of which these data can be scrutinized.

Frequent group meetings are essential on a psychiatric service. At Mount Sinai we start off each day with a group meeting attended by all patients capable of doing so, as well as the full complement of ward personnel. For the physicians this represents a way of making rounds. Much else is achieved by the morning group. The entire staff gets to know all the patients, and vice versa. In this way we avoid the fragmentation of the ward into a number of supposedly unrelated psychiatrists. This morning group meeting is followed by a brief "bull-session" of all the residents where the significance of specific occurrences in the morning group is discussed. The patients tend to follow up the discussions of the morning group in bull-sessions of their own.

In recreation and occupational therapy, trained workers not only direct the activities but also collect data

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* *Drs. Richard D. Chessick, Edward M. Wasserman, Francis J. Gerty and Miss Mary Huels, R. N.*

which are communicated in formal staff meetings which occur three afternoons a week. Patients are kept aware of the fact that there is a free flow of information between all departments for their common good. These data form the basis of our understanding of each case, and administrative decisions are then able to be individualized in terms of specific therapeutic goals.

Perhaps a single brief example will make this point more clear: At one of our afternoon meetings the nurses reported, with some distress, that female patients were entertaining male visitors in private rooms behind locked doors, and that considerable sexual acting out was taking place. It would seem obvious from an administrative point of view that such physical intimacies could not be countenanced on a hospital ward. However, to have stated so in an administrative fiat would have missed the whole point. Group discussion brought out that this acting out started rather abruptly during the preceding week, that it took place not only on the ward with visitors but in recreation situations with patients from other wards. In short, we were dealing with a group symptom. Further discussion elicited the fact that this behavior started following the admission to the ward of a beautiful and actively seductive female homosexual. Her presence had quite clearly aroused homosexual fears in the patients, against which they defended themselves by flight into heterosexual acting out. With this understanding it became possible for each psychiatrist to take up the homosexual inclinations and fears of his patients in a psychotherapeutically meaningful way. In a very short time the inappropriate sexual behavior subsided. Thus, what seemed at the outset to be an administrative problem proved to be an interesting "experiment in nature" demonstrating unconscious homosexual impulses and the psychological defenses against them. Most important of all, the experience handled this way provided a valuable opportunity to foster the emotional growth of each patient.

Many more examples could be cited in which an overt administrative problem conceals a complex problem in psychotherapy, involving unconscious impulses and defenses against them in a group setting. Considering this, there can be no separation of administration and treatment but rather a group effort unified by a single goal, namely, the optimal treatment of the individual patient.

Dr. Chessick and his co-workers recognize this—in fact they state it explicitly. "Ward interaction," they say, "involves everybody, and patients act out, become psychotic, regress, restitute, and run away in many cases directly as a result of the ward interaction." However, this position is not maintained consistently throughout the paper. The very fact that one splits a ward population into two groups so that one third gets one plan of care and the remainder another, is basically unsound from a psychotherapeutic point of view. This kind of split in the outer world intensifies the intrapsychic split with which most of these patients struggle, and tends to intensify the basic psychopathology of each patient. This fact was well documented by Stanton and Schwartz. There is some confirmation of this expectation in the authors' comment that some patients felt "hopelessly confused by having two physicians." That the project also had a splitting effect on the house staff is expressed in the statement that their "over-all opinion seemed equally divided" when asked for their evaluation. There is even a hint of a split between the authors and the rest of the staff in their comment that "it would be very difficult to determine whether the (negative) feelings (of the house staff) resulted from the test or from previously-held views."

In a letter it is obviously not possible to deal exhaustively with the vast and complicated questions which have been raised by this paper. However, I would summarize my point of view as follows: The task of the ward administrator centers primarily about the resolution of conflicts on the ward, involving patients and personnel alike. It centers about the creation of a realistically unified and harmonious atmosphere dedicated to the emotional maturation of the patient. This can be done only by the careful collection and sifting of data, and the formulation of plans individualized for each patient and applied consistently in accordance with a scientific theory of behavior. As to the latter, I have found the psychoanalytic point of view most useful. In my opinion, it is from the lack of a clearly stated theoretical base that the authors' work suffers most.

LOUIS LINN, M.D.

What are the Specific Indications for Role-Splitting?

(Dr. Greenblatt, Assistant Superintendent of Massachusetts Mental Health Center, Boston, submitted the paper to Myron Sharaf, a social scientist; three senior psychiatrists, Drs. Gertrude Rogers, Leston L. Havens and Gerald L. Klerman; and to Dr. Edward J. Sachar, a second-year resident. The paper was made the subject of a staff conference, and Dr. Greenblatt's letter is a distillation of the comments, plus some of his own thinking.)

YOU CAN SEE by the length of my letter how much interest this excellent paper stimulated. In making our criticisms and suggestions, we appreciate that the authors have tried to comprehend some very complex problems in an area that has been subject to little systematic research. All of us feel that the points raised were most timely and interesting. If our discussion appears rather sharp, it is in response to your direct request for critical opinion.

We felt that the paper was formulated at a fairly general level of conception and was not explicit enough as to types of patients, type of hospital, staff-patient ratio, etc. We could use more vivid examples to give substance and meaning to the presentation. Although the problem is well highlighted, the analysis in logical terms leaves something to be desired. Because of the general nature of the paper, we find it difficult to compare their model of administrator-therapist split with our own.

The paper does not differentiate between the ward administrator's responsibility for the patients' milieu (the social life, the physical environment, etc., of the

whole ward), and the responsibility of the patient's administrator. In the first case, the whole ward is the unit under the command of an administrator, and individual patients may have psychotherapists. In the second case, the individual patient is the unit; he has both an administrative doctor and a psychotherapist. Experience and study are needed to outline the values of each technique.

An important desideratum is to delineate carefully the kinds of problems met with, so as to determine eventually, in an accumulated experience, for which types of patients the split is desirable. Is it, for example, primarily indicated for patients with "acting out" tendencies? There is some feeling that the degree of role-splitting can vary considerably, with sharp division perhaps best for patients with behavior disorders, who cannot separate in their minds outer reality from emotional cathexis.

The experience quoted is with six to eight patients and one administrator. More cases would be needed to bring a conclusive philosophy to this experiment.

Several questions arise: What was the specific nature of the contacts and communications made between the parties involved? What kinds of interactions occurred between the administrator and the individual therapist? What was the degree of agreement versus disagreement in the setting of goals and in the fulfillment of their roles? What did the patient know about the communications between administrator and therapist, and how did he react to this information? We would like to know more of what is required of either the ward administrator or the patient administrator in terms of interpersonal skills with both personnel and patients in order to fulfill the divided roles adequately.

The part including the survey of hospitals in the Chicago area is sufficient to whet our appetites; however, we feel that in the future the size of hospitals, staff, treatment philosophy, etc., should be spelled out more. Here is an area that could easily be a paper in itself.

In general, it appears to us that the splitting of the roles of administrator versus therapist can be of varying degree, but probably cannot be made total. Essentially the two doctors are undertaking a variation of role-playing technique in order to abstract the patient's problem (of differentiating the reality of external authority from his neurotic identifications) and, in addition, to make his problem more concrete and dramatic. However, both administrator and therapist need continuous clarification of their roles, as well as practice, in order to achieve smooth interplay. Considerable communication will be needed between them so as to obtain agreement and unity in their total relationship to the patient. It is felt that "acting-out" patients, who manipulate authority so readily, need, perhaps more than other patients, authority to stand firm, to make reality very plain, almost automatic. Perhaps the greater the confusion in the patient's mind, the greater the need for a split in roles. However, we feel that role-splitting should be based on specific indications, which are still to be spelled out. It should not be called into play merely because a therapist is too weak to be firm in administrative matters.

We should also recognize the possibility that some patients need one figure in their life who combines both the therapeutic and administrative roles effectively and firmly, for this is how life is usually experienced, especially in the earlier years. Perhaps with some children and adults, it would be more natural to have unity in this respect rather than separation, and in some cases perhaps the therapist can only be seen as a potent person if he can carry out both functions.

However we look at it, the therapist-administrator split complicates life, for it implies the use of more people and more time which may not be available in some hospital organizations.

MILTON GREENBLATT, M.D.

Administrators Are More Than Shock-Absorbers!

CONGRATULATIONS to the authors of the paper "The Psychiatric Ward Administrator" in the March issue. Their interesting study, supplemented by a review of the literature and of practice at selected hospitals, is a stimulating and timely recognition of the value of "situational therapy" and of the administrator's creative role in the treatment situation. Acknowledging the powerful effect of social processes within the ward during the 98 per cent of the time when a patient is not with his therapist, they remind us that "ward atmosphere" is the result of policy-making and administrative decisions.

A reading of this excellent paper leads one to contemplation of the anomaly by which an administrator's need for training in therapy is taken for granted, while a therapist may shun the rigors of administration and even pride himself on his virginal innocence of business and finance. The responsibilities assigned to the ward administrator during the test period at the University of Illinois make an instructive list of borderline functions. Who will say which are administrative and which therapeutic? At least it would seem there was scant agreement when inquiry was made at various hospitals.

The management of the patient, his relatives, and the environment—the administration of the total situation—is an important factor in a treatment situation. Physicians, and particularly psychiatrists, place limits to their own usefulness when they remain unfamiliar with this important phase of therapy. It is to be hoped that in the near future every psychiatric resident will receive intensive training in psychiatric administration and will actually be given certain administrative responsibilities. Subsequently he can either avail himself of one of the numerous administrative opportunities or be a better therapist for having had the experience. If he enters private practice, he will find that many of the problems of administrative psychiatry arise there too.

Pedestrians without driving experience figure in a disproportionately high number of traffic accidents because they overestimate the performance potential of automobile brakes. A physician without a knowledge of the cultural, situational, and financial determinants of illness will be similarly handicapped in many of his judgments.

Finally, a word of appreciation to the authors for presenting administrators as something more than shock absorbers for therapists who do not wish to be identified with an authoritarian role. While administrative skins are tough enough to absorb considerable hostility for the sake of effective psychotherapy, they also respond with a glow to occasional and judicious applications of the tender balm of understanding.

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Administrative Psychiatry is a Positive, Therapeutic Agent

THE AUTHORS are to be complimented in the design of their experiment "that the value of a routine division of roles should be tested." In examining the literature one cannot help being impressed with the many observations regarding administrative physicians, psychotherapists, milieu, etc. Most of these observations are made in clinical-administrative settings which have evolved because of belief, expediency, or trial and error. Few, if any, such settings have been organized for the purpose of validating the soundness of the clinical attitude espoused. This, too, is understandable. In treating humans we are most hesitant to withdraw or deny any therapeutic program which we think will assist in their recovery. This has been as much a problem for psychiatrists as for other physicians and has perhaps often hampered the testing and the broad dispersal of sound therapeutic agents. Thus the conclusions derived from the authors' experiment have considerable significance. The authors' presentation suffers in but one major, and I assume not self-imposed, area. Because of limited publication space they were forced to cover too many subjects with too few detailed examples.

The authors do cite results of the greater individual consideration offered the patients under the administrator-psychotherapist split: a) "anxious demandingness was less often used by manipulating patients"; b) patients who were specially handled "tended to give requests in detail to the charge nurse." These two examples are well chosen because the "anxious demandingness" and non-detailed requests are two prime means of arousing discomfort in *all* personnel (doctors included) and are often the cause for reprisals or the "substitutes for listening"—restraints, hydrotherapy, drugs, ignoring the patient, etc.—to which the authors refer. The authors thus have outlined the pathology and demonstrated an effective treatment.

They start with the assumption that "a beneficial atmosphere does not ordinarily result from accidental or fortunate circumstances. It is the result of deliberate policy-making and administrative decisions." In their concluding paragraph they say, "Some ward administration with specific responsibility for atmosphere seems mandatory for every mental hospital. This is because the 'other 23 hours' can either support or directly oppose the therapeutic process." In the body of their article the authors present a convincing case for administration's coming into its own as a therapeutic agent. They equally stress that effective patient-oriented administration requires time: time to listen to patients and personnel; time to take care of details today and not in the indefinite future; time to develop a therapeutic environment.

In many hospitals the junior physicians become ward administrators. The least experienced person, with the least authority, the least status, and perhaps with the greatest anxiety, is placed in the position of being either a) greatly responsible or b) just an errand boy. This is indeed a most effective means for dulling the young psychiatrist's curiosity about people or emphasizing the virtues of the deadening effect of drugs or the shock machine. Thus the very atmosphere of relegating administration to a lower status may reinforce its uselessness.

Through what seems to have been sound investigation the authors corroborated and validated that administrative psychiatry can be a positive therapeutic agent in itself and a complementary agent to other therapies.

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FILM REVIEWS

This month's film column is devoted to three films of special interest to hospital personnel. Two of them, BROKEN APPOINTMENT and THE FEELING OF HOSTILITY, have just been added to the A.P.A. Mental Hospital Service Film Library and may be borrowed by members.

BROKEN APPOINTMENT (30 minutes, black & white, sound.)

This film tells the story of Susan Burke, a public health nurse, who learns that understanding a patient's emotions can be as important as interpreting physical symptoms. Although this film does not have a mental hospital setting, a number of mental hospitals have been using it in nursing instruction. And there is a good reason for this. Through its moving human interest story, it drives home the importance of talking things over in developing an understanding of other people's (and one's own) motivation.

When Susan has a problem, she talks things over with

New Catalogues in Mail

New film catalogues and booking forms, containing details of our two new films, BROKEN APPOINTMENT & THE FEELING OF HOSTILITY, have been mailed to the superintendents of subscribing hospitals. Old forms are no longer valid and should be destroyed. Additional copies of the new catalogue and booking forms can be obtained free of charge from M.H.S.

A special edition of the catalogue and special bookings forms have been sent to the eleven western states that will be served by our West Coast Film Depository in Sacramento. Requests from these states —Arizona, California, Colorado, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington and Wyoming—will be serviced only by the West Coast Branch of the M.H.S. Film Library.

her co-workers, with her supervisor and with her agency's mental health consultant (who would, in a hospital setting, be a psychiatrist). She also talks things over with her patient, an expectant mother, and gets the patient to talk with her husband who does not want her to have the child.

In spite of all the talk, BROKEN APPOINTMENT is an effective delineation of a basic tenet of human relations. Its concept will not be new to social workers or psychiatric nurses, but it may be new to student nurses affiliated with psychiatric hospitals. Although the nurse in the film is not working with psychotic patients, the things she learns about understanding emotional factors are just as applicable to psychiatric nurses. Especially valuable are the conference sequences and the nurse's self-analysis. The setting—a coal mining community—is an interesting one, and the production as a whole is of high quality. The Mental Health Film Board, producers of the film, have provided two discussion guides to accompany the film—one for use by nursing instructors and one for use by discussion leaders.

THE FEELING OF HOSTILITY (33 min., black & white, sound.)

Although not a new film, this study of emotional inadequacy deserves a review in this column because it is a recent addition to the Film Library. One of the most popular of the justly-famous Mental Mechanisms Series of the National Film Board of Canada, THE FEELING OF HOSTILITY dramatizes the factors producing resentment and hostility in personal relationships. In the story of Clare, we see how the death of her father and the later remarriage of her mother discouraged her in the seeking of affectional relationships with others. Because she finds some satisfaction in others' approval of her intellectual ability, young Clare determines to excel and gets ahead rapidly at college and in her business career. Despite such success, however, her life is a sterile one—lacking fellowship and understanding. The factors behind Clare's emotional immaturity are reviewed by a psychiatrist, in a trailer which suggests how parents can help their children avoid similar problems.

A lucid script, some excellent performances and several fine directorial touches overcome the gloom that might be induced by the bleakness of the physical production and the somber story. This award-winning film is one of the pioneer efforts which gave the Canadians such a fine reputation for making superior mental health films.

SKF PSYCHIATRIC NEWSREEL #1 (20 minutes, black & white, sound.)

For its first issue, THE PSYCHIATRIC NEWSREEL (a new service of the Mental Health Education Unit, Smith Kline & French Laboratories), features a film report on some recent events in psychiatry and covers quite a lot of ground in its 20 minutes.

First to be seen are intriguing glimpses of the new state hospital at Hollywood, Florida, with special attention given to its architectural innovations—separate housing units, one-story construction and security enclosures which are decorative as well as functional.

Next we go to Philadelphia for an informal chat with the past medical director of the A.P.A., Dr. Daniel Blain.

In Rome, Italy, we are shown brief shots of (and sometimes interviews with) the conferees at the First International Meeting on Psychopharmacology.

The last and longest sequence concerns submarine psychiatry at New London, Conn. Captain Jack Kinsey, M.C., the first submarine psychiatrist, reports on his voyage under the polar cap on the Nautilus, while the audience is shown how life on that atomic-powered submarine differs from life on ordinary submarines. There were no psychiatric casualties on the voyage, and this Capt. Kinsey attributes to the high morale of the crew. In submarine psychiatry, accent is on prevention, and Capt. Joe Vogel, M.C., Director of Research at the New London submarine base, explains how each crew member of the Nautilus received a careful psychological examination before assignment to the atomic submarine. Actual shots of the rigid physical training of the crew illustrate Capt. Vogel's comments.

Suggested uses for this film: Meetings of local psychiatric associations, medical societies, mental health associations; mental hospital personnel, and students in psychiatry and psychiatric nursing.

PSYCHIATRIC NEWSREEL #1 is currently being distributed to state and VA hospitals by SKF's Hospital Sales Service representatives. Upon completion of this distribution it will be available upon request from SKF's Medical Film Center, Philadelphia 1, Pa. After June 1 it will also be available from M.H.S. Film Libraries.

JACK NEHER

BOOK REVIEWS

CHRONIC SCHIZOPHRENIA—By T. Freeman, J. L. Cameron, A. McGhie, with preface by Anna Freud, 158 pp. International Universities Press, New York, 1958

This small book from Scotland describes a theoretical framework for the treatment of chronic schizophrenic patients in hospitals. The actual treatment methods utilized are very similar to the milieu and relationship types of therapies being introduced into American mental hospitals in recent years. However, a theoretical rather than an empirical basis permits a systematic implementation of the treatment approach.

The authors present a brief review of the psychoanalytic conceptions of mental functioning and review also the psychopathology of schizophrenia as viewed by various schools of psychiatric thought. The selections from the literature have been chosen carefully for their relevance to the discussion.

The theoretical formulation advanced here characterizes the psychopathology of schizophrenia as follows: "... The ability to differentiate the self from the environment ... is damaged, thus leading to the patient's experiencing internal and external sensations as a continuum. We believe that once this basic disturbance is appreciated, all other schizophrenic manifestations can be viewed as necessary elaborations of it" (p. 51). Schizophrenia is considered a disorder of the ego. The normal continuum between the ego and the outside world is grossly disturbed.

Using clinical material drawn from patients on a men-

tal hospital ward for regressed schizophrenics, the authors find support for their thesis. They discuss and illustrate symptoms of confusion of identity and disturbances in thinking, perception and memory. They describe how these symptoms became intelligible to the onlooker when viewed from their theoretical frame of reference.

Based on this theoretical approach, an experimental ward was established at the Glasgow Royal Mental Hospital. By means of ward procedures and functions, ways were sought to provide the patients with experiences that would serve to strengthen ego functions—to assist them in differentiating their internal and external environments. Patient freedom, occupational therapy, ward housekeeping, personal cleanliness, relatives' visits and home visits were aspects of the therapeutic program. The basic element in the process was the emotional relationships of patients with nurses. The nurses were seen as the key figures because of their constant presence on the ward. The ward nurses could not have assignments shifted often because of the need to maintain the nurse-patient relationship. The physician's task was to train the nurses and to guide their therapeutic role.

The book will be of great interest to those who work with chronic schizophrenic patients and may be helpful in clarifying the rationale for our current treatment approaches. It is highly recommended.

LUCY D. OZARIN, M.D.

SYMPOSIUM ON PREVENTIVE AND SOCIAL PSYCHIATRY

A symposium on Preventive and Social Psychiatry, sponsored by Walter Reed Army Medical Center and Institute of Research and the National Research Council was held in Washington in April 1957. A published verbatim 529-page report of the meeting is now available from the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D. C., price $2.00.

The major areas covered are:

Communication, values, influence and group structure
Ecology and epidemiology of mental illness
Industrial psychology and psychiatry
Significance of leadership for the mental health of groups
Social psychiatry in the community
Development of a therapeutic milieu in the mental hospital

The symposium included formal papers and discussion of these papers. The participants represented a number of professional disciplines both from this country and from abroad. Bibliographies are appended to each presentation and include recent references to work in the areas covered. The section on Mental Hospitals discusses theoretical approaches to recent developments in mental philosophy and practices.

LUCY D. OZARIN, M.D.

RECREATION FOR THE MENTALLY ILL

This booklet is a report of the National Conference on Recreation for the Mentally Ill which was held in November of 1957. It was sponsored by the American Association for Health, Physical Education, and Recreation, a department of the National Education Association. The stated purpose of the conference was ". . . to provide a national forum at which recognized leaders of hospital recreation and other concerned professions might assemble, analyze, and synthesize their views. . . ."

The amount of space given to reporting the events that led to the conference, the organizations and individuals represented, and even such minutiae as the dates on which invitations were sent may seem out of proportion. However, the fact that 18 different societies and agencies were represented at this meeting suggests the diffuse and confusing situation in the field.

There are three chapters which are particularly worthy of note. *Professional Attitudes and Practices* is devoted primarily to the role of recreation and the use of leisure time as important aspects of a healthy existence. It is stated that "The professional recreation leader is dedicated to the concept that how man uses his leisure not only determines but expresses and measures the nature and extent of his personality growth and self-fulfillment."

Facilities and Equipment contains an excellent discussion of general principles regarding equipment for recreational activities. A philosophy of the function and role of recreation within a psychiatric hospital is implied by ". . . personnel engaging in hospital recreation might more profitably define themselves as teachers than as clinicians, the patients as students, and the results of their efforts as imparting knowledge and developing skills. . . . If one contrives a device intended to release the 'free expression' or 'latent aggression' of people, it will not have recreational value. . . ."

Evaluation and Research expresses the viewpoint that research is not necessarily a complex process subject only to the microscope of the basic scientist. Many practical suggestions and bits of advice are given to the would-be researcher. The point is made that ". . . any professional group working with the mentally ill will have its maturity and effectiveness judged by the level of its self-evaluation."

The appendices make up 31 pages of this 77-page report. For the most part, they contain reference information relative to the conference and to recreation in psychiatric hospitals.

Included is the paper "Hospital Recreation—A Medical Point of View" by Paul Haun, M.D. The author's thesis is quite simple, and succinctly stated thus "Since the sick patient is first of all a person, he brings into the hospital along with his illness a vast range of essentially human needs. . . . It is *because* I believe that recreation is an essential human need that I want it for my patients. . . . The recreation worker . . . can make the patients' healthy psychologic needs his sole and exclusive concern." Dr. Haun does not regard such activities as therapy. This reviewer is in agreement with the editor that Dr. Haun's article does present ". . . a coherent and integrated philosophy of recreation for the mentally ill." While some may disagree with the philosophy or feel the need for revision, it is at least one clear formulation in an area generally characterized by vagueness and confusion.

Appendix F should also be mentioned, as it lists and discusses ten "Qualities of the Professional in Hospital

Recreation," which are presumed to characterize the "professional person" in contrast to the layman or non-professional.

This report contains relatively little of a clinical or theoretical nature except for the article by Dr. Haun and the comments in the chapter on *Facilities and Equipment*. However, the presentation of a specific viewpoint (however controversial) and the information regarding practical aspects of the general field of recreation make it a booklet of value to anyone concerned with the rehabilitation of psychiatric patients.

HAROLD R. MARTIN, M.D.

NEW PRODUCTS

Mental hospitals are big business, as we've said before; annually they spend an estimated half a billion dollars, not counting payrolls. For the benefit of the many personnel throughout institutions and central agencies who play a part in selecting and purchasing goods, this new column will examine some of the product innovations and improvements coming onto the market. MENTAL HOSPITALS' *contributing editor for new products, Mr. Alexis Tarumianz, who is business administrator of the Delaware State Hospital, will report from time to time on items he considers of special interest to psychiatric institutions. Many of these items have been or will be tested at his hospital specifically for this column.*

FLAMEPROOF DRAPERIES

An attractive flameproof drapery material called Saranspun is available both in plain colors and in prints. It is woven from a man-made fiber, Saran, which is produced by the Saran Yarns Company of Odenton, Maryland. The plain fabrics are available from The Georgia Company (276 Fifth Avenue, New York 1, N. Y.) and the prints from Mead & Montague, Inc. (245 Fifth Avenue, New York 16, N. Y.)

For testing purposes for this column, The Georgia Company and Mead & Montague each donated 15 yards of fabric. We had the solid-colored cloth, a soft shade of green in a woven stripe pattern called Saranara, made into drapes for a remodeled dining room for women patients. The other sample is a handsome modernistic design of large "teardrops" in two shades of gold on a white background. We plan to have it made into drapes for another dining room.

The Saranara drapes have proven very satisfactory, both in appearance and in practicality. The fabric is a medium-weight, semi-sheer, 48 inches wide, which drapes well. According to its manufacturer, Saranspun material is mothproof and mildew-resistant, non-allergenic and unaffected by humidity or temperature changes. Our test drapes have been up only three months, so we cannot yet verify these claims nor those that the material holds its original dimensions (i.e., does not sag or shrink appreciably), is fadeproof and long-lasting.

We did test its washability and found that the drapes looked well enough to be hung without ironing after being drip-dried.

Saranara costs approximately $2.50 a yard, which would make the cost of a pair of 54-inch drapes run about $10 plus labor. This makes a relatively high cost for some mental hospitals, but if appearance is important—and it should be—and if the fabric does prove durable and easily maintainable, then the cost might not seem so great, especially when you consider that the fabric is permanently flameproof.

DURABLE WALL COVERING

Another product which we are testing in the same dining room is a wall covering called Fabrique. This is a vinyl-impregnated, non-woven wall cloth that comes in a wide selection of attractive designs and solid tints.

Fabrique's manufacturer, the Birge Company (390 Niagara Street, Buffalo, N. Y.) gave us a large enough sample to cover the dining room's 447 square feet of wall space. Each roll measures 21 feet long by 20½ inches wide, with two rolls to a package, offering 72 square feet of coverage. The suggested retail price runs from $3.20 to $3.85 a roll (about 10¢ a square foot) but no doubt hospitals could arrange a lower price for quantity.

The material is very easy to apply with a wheat or cellulose paste, and the joining edges do not need to be lapped. Fabrique is said to have sufficient elasticity so that it can expand and contract along with walls during temperature and humidity changes and the normal settling of buildings. Also, its weight and flexible embossed texture permit it to be hung over most textured wall surfaces so that bumps and ridges do not show through.

Fabrique is also easy to care for. It resists practically all stains, even grease and ink, and may be washed with soap and water. Stubborn stains should be scrubbed with naphtha or turpentine before being washed. According to test reports from Birge's own laboratories, the only substances which will mar Fabrique are lacquer thinner, nail polish remover and carbon tetrachloride.

Patients' dining room takes on a cheery atmosphere with attractive and durable wall covering and draperies.

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"It is obvious that we have in ['Stelazine'] a very effective drug which often produces results where other treatment has failed."

Gunn, D.R.: The Role of Trifluoperazine in the Treatment of Refractory Mental Patients, in Trifluoperazine: Clinical and Pharmacological Aspects, Philadelphia, Lea & Febiger, 1958, pp. 47-53.

"... the majority of patients treated—formerly considered practically hopeless—are now in some way more easily managed on the ward."

Klimczynski, J.J.J.T.: Treatment of Chronically Ill Psychotic Patients with Trifluoperazine: A Preliminary Report, *ibid.*, pp. 101-112.

"The relatively low number of failures of treatment, even in those who have been sick for a long time, must be considered almost as significant as the high proportion of good recoveries."

Goldman, D.: Clinical Experience with Trifluoperazine: Treatment of Psychotic States, *ibid.*, pp. 71-86.

Available: Tablets, 2 mg., 5 mg. and 10 mg.
Multiple dose vials, 10 cc. (2 mg./cc.)

Literature available on request.

Smith Kline & French Laboratories (SKF) leaders in psychopharmacology

*Trademark for trifluoperazine, S.K.F.
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PROBLEMS OF FIRE PROTECTION IN MENTAL INSTITUTIONS

By CHARLES E. GOSHEN, M.D.
A.P.A. Architectural Study Project
Washington, D.C.

MENTAL HOSPITALS present unusual fire protection problems and require more diligence than other institutions in the maintenance of satisfactory safety standards. Not only is fire protection complicated by the security devices which make evaluation a special problem in the event of fire, but the patients are likely to be careless and uncooperative with protection procedures. The personnel shortage imposes a further source of potential hazard. To complicate the problem still further, there are many acres of floor space in old mental hospitals, which were built without due regard to fire hazards.

In addition to the many well-known and fairly obvious fire protection measures, there are others which are easily overlooked, especially in new construction and renovation. Following is a check list of practical hints which should be taken into account in setting up a long-range fire protection program. Much of the material presented was obtained from the National Fire Protection Association (60 Batterymarch St., Boston, Mass.).

1. General Design Considerations.

(a) The amount of unencumbered space provided in any area of a building must be designed with the realization of the extent of the fire damage which could result in that area. Small areas tend to limit the extent of fires and less damage will result than in a larger area.

(b) The height of a building must conform to the limits imposed by local fire-fighting equipment. Local fire departments are prepared to advise on these limits.

(c) Not only must the combustibility of the construction materials be considered, but also the combustion properties of the movable contents. Modern buildings (except residential dwellings) are likely to be highly fire-resistant, but the contents of the building can be a great fire hazard.

(d) The horizontal area of each floor of a building is an important consideration in design. In the event

of fire, it is often impossible for the fire department to enter the building, so that the attack on the fire must be carried on from outside. If the floor expanse is too large, it may be impossible for streams of water through the windows to reach the fire. Automatic sprinkler systems can make possible the design of larger areas because the sprinklers can pour water on the interior parts of the building. Often building codes are not sufficiently explicit in their specifications of sprinkling systems, and the installation of the minimum equipment required by a local code may not offer adequate protection.

(e) Fire walls dividing different parts of a building can create independent units which will help limit the risk in the event of fire.

(f) All new multistory buildings should be of fireproof construction.

2. Protection of Openings.

(a) The closing of the various openings in a building (doors, windows, shafts, stairwells, etc.) is vital. The importance of this rule in fire protection relates to the access they provide for air which can support combustion, or access to neighboring areas for the spread of fires.

(b) Vertical openings, like stairwells and shafts, are particularly significant because they may act as chimneys, helping the fire spread to higher levels in the building. Fire doors are often installed to serve as fire retardants. To be effective, these must be provided with spring devices to keep them closed. Sliding, rather than hinged, fire doors are desirable for large openings.

(c) When it is necessary to provide fire doors which must be kept open for periods of time, it is preferable to provide a heat-actuated device to cause them to close automatically in the event of fire.

(d) A balance between two opposing considerations must be achieved in the choice of the number of doors. On the one hand, a larger number of doors increases the chances of fire's spreading through them but, on the other hand, they provide better egress in case of fire.

(e) The size of door openings should be at least 6 ft. 6 in. high and no wider than necessary to handle the traffic.

(f) Vertical shafts (elevators, dumb-waiters and ventilators) should be lined with fire-resistant material and able to be sealed at the top to prevent chimney-like effects.

(g) Doors which provide egress from a building should be swinging in type and in most cases should open in the direction of travel.

3. Furnace and Incinerator Rooms.

(a) In large incinerators, auxiliary fuel (gas or oil) is generally provided to ignite and encourage the complete combustion of trash. A safety valve should be provided between the fuel supply and combustion chamber to automatically shut off the fuel supply.

(b) Incinerator and furnace walls should be constructed of clay, shale brick, firebrick or metal on the inside, with sufficient exterior reinforcement to withstand considerable pressure from within (explosions).

(c) All furnace and incinerator rooms should be provided with sprinkler systems.

(d) Rubbish waiting for incineration should be contained in metal cans supported on noncombustible foundations (masonry).

(e) The partition walls of these rooms should be built of the equivalent of six inches of reinforced concrete, with metal fire-doors and fire-windows in the openings.

(f) Smokestacks for large incinerators are major engineering problems and should be designed only with adequate expert consultation.

4. Waste and Rubbish Disposal.

The safe collection and disposal of combustible waste or rubbish requires a wide dispersion of many conveniently located waste containers. The type of waste involved is generally paper. Waste receptacles are best made of metal and of suitable size to handle the maximum amount of waste likely to be produced in a given area in one day. Daily emptying of these receptacles is an obvious necessity.

Rubbish chutes can be useful in large buildings to dispose of collected waste. Care must be exercised in their construction and location because of the large chance of their containing combustibles within a chimney-like structure. This generally prohibits their use in buildings having a low fire resistance. They should be lined with fire-resistant material (usually metal), and self-closing fire doors at the openings are advised.

When large amounts of waste paper must be disposed of routinely, it often pays to use a baling machine to render the paper suitable for sale to salvage collectors. The principal fire hazard lies in the large collections of paper waiting for baling. It is essential that the storage of this waste be confined to fireproof rooms of a building or separate buildings. Waste paper waiting for incineration also poses a major fire hazard, requiring the storage of the waste in fireproof containers in rooms suitably fireproofed.

5. Combustible Contents.

In the old days, fire hazards in typical buildings tended to be of two types: (1) the heat hazard produced by the burning of combustible building materials, furniture, etc. which were generally wood, cotton, wool and paper; and (2) the mechanical hazard caused by the collapse of structures weakened by fire. Today, however, the advances made in the development of fire-resistant construction have largely reduced these dangers. Instead, fire casualties tend to be produced largely by inhalation of smoke from the burning of combustible contents of buildings. Most of the deaths at the infamous Coconut Grove fire in Boston in 1942 (almost 500), for example, were due to lung damage, and not directly to burns.

The newer plastic materials, used to make furniture, floor and wall coverings and fabrics, are likely, when exposed to high temperatures to produce highly toxic fumes. Institutions often contain stores of materials such as floor waxes, detergents, petroleum products, insecticides, fumigants, etc. which may produce toxic fumes when subjected to high temperatures. One of the principal sources of danger in fires from these effects lies in the lack of awareness of their danger. Often what seems to be a minor structural fire may produce many casualties

from fumes, only because personnel fail to realize the hazard.

The most effective protection against these toxic fumes is fresh air. Evacuation of patients and personnel from the building can often be safely accomplished by having the people keep their heads close to the floor, taking advantage of the tendency of these fumes to rise. Shutting off the unaffected areas of the building by closing doors to the burning part is especially important. Even though an efficient sprinkler system has extinguished such a fire, it is important to ventilate the building before permitting people to re-enter.

6. Garages.

(a) Garages should be of "fireproof" or "semi-fireproof" construction, depending upon proximity to other buildings, available means of egress, etc.

(b) When a garage is a part of a building used for other purposes, it should be separated from the rest of the building by fire walls and fire doors.

(c) Underground garages should be provided with forced air ventilation, and no gasoline should be stored in such areas because of the danger of fume traps.

(d) Heating equipment should be separated from garages by fire-resistant partitions.

7. Ventilating, Air Conditioning and Hot Air Heating Systems.

(a) Ventilating systems in institutions should be adequate to provide for the removal of smoke and noxious fumes. Their capacity should be such as to cause a complete turnover of air in five minutes.

(b) Duct-work should be entirely of noncombustible material.

(c) No work involving flames (blow torches, etc.) should be done on a ventilating system while it is in operation.

(d) Special vigilance should be maintained to seal off unserviceable openings in duct-work.

(e) Duct-work should not be closer than ½ inch to surrounding combustible construction (lath, wood framing, etc.)

(f) Openings for ducts through floors should be sealed with fire-resistant materials.

(g) The area surrounding the air intake should be kept free of flammable material or noxious fumes.

(h) A manual emergency switch should be easily accessible and suitably labeled for ventilating systems.

(i) In institutions where the presence of atmosphere smoke is likely to engender panic, it is wise to incorporate smoke detectors which automatically close down the system when smoke appears. These relatively new devices are photoelectric-actuated and are installed inside the ventilating system.

8. Fire Protection and Alarm Equipment.

(a) Fire procedure instructions should be prominently displayed in various areas of an institution, and personnel made thoroughly familiar with them.

(b) Fire drill discipline is an absolute necessity to develop in mental hospitals, and should include specific assignment of responsibilities to all personnel.

(c) Fire drill instructions and training should emphasize life-saving procedures, not fire-fighting.

(d) In institutions, automatic or manually-operated fire alarms should be installed in each building and on each side of fire walls.

(e) Fire alarms should be serviced by a responsible person at regular, frequent intervals, and promptly restored to service after use.

(f) In buildings housing deaf patients visual as well as auditory signals should be provided.

(g) Manually-operated sending stations (fire alarms) should be located near all main exits, and at least one on each floor.

(h) Automatic fire detection apparatus is useful, but requires frequent servicing.

(i) Prominent and adequate fire-exit signs should be placed over exits, and permanently illuminated.

(j) Fire escapes are devices to be used only in existing buildings. New buildings should make adequate provision for fire escape without the use of appended balconies and stairways. Even the best fire escape systems have serious deficiencies, but must be resorted to in rendering old buildings safe.

(k) Two means of egress should be available not more than 100 feet from any point in the building.

(l) Automatic water sprinkler systems constitute about the best available method of improving the fire protective properties of old buildings.

9. Definitions and Standards.

(a) *Combustible:* General term meaning the capacity to burn, without reference to any specific ignition point.

(b) *Fireproof:* Originally meant "absolutely incombustible", but since no material is absolutely free of combustion properties, the term has come to mean "a high degree of fire-resistance."

(c) *Fire-Resistant:* Having a high degree of incombustibility but not as high as "fireproof." Often defined further in terms of hours.

(d) *Fire-Retardant:* Having fire-resistant properties to a relatively low degree. Usually refers to a fire-resistant covering over a more combustible material which serves to slow down the progress of combustion.

(e) *Flameproof:* Refers to a property of materials which, though combustible, will not be likely to break into flame or propagate a flame.

(f) *Flammable and Inflammable:* (Though technically opposites, have come to be synonymous in popular usage.) Having the property of being freely combustible, and capable of supporting and propagating combustion.

(g) *Fire Door:* A fire-resistant door (sheet metal, hollow metal or metal-clad) which closes an opening through which there is potential danger of fire spread.

(h) *Fire Window:* Heavy, wire-reinforced glass in metal frame, covering openings to spaces which are likely to contain fire (furnace rooms, elevator shafts, etc.).

(i) *Non-Fire-Resistive Building:* One which cannot withstand the burning out of the interior without collapse. This generally includes: (a) frame (wood) construction of inner and outer walls; (b) masonry exterior and wood interior walls; and (c) incombustible walls supported by timber structural members.

(j) *Fire-Resistant Building:* One which withstands collapse after a fire which destroys the contents. This includes types of construction where both walls and supporting structural members are made of incombustible material (masonry, steel, etc.).

(k) *Fire Protection Properties of Cabinets, etc., for Record Storage:* Record vaults, filing cabinets, safes, etc. are rated according to the number of hours they can protect their contents (paper) from an environmental temperature of 2000° F. A filing cabinet may be rated, for example, as "two-hour protection." The degree of protection required will depend upon the amount and value of the records stored. Very valuable records should have duplicates made which are stored at a distant point.

(l) *Standard Fire Test:* Materials may be tested for their fire-resistant qualities by measuring the time they withstand certain test conditions. They are put into an oven which is then heated to reach specific temperatures at specific times, rising from 1000° F. at the end of five minutes to 2300° F. at the end of eight hours. The rating is in terms of the number of hours the materials are able to withstand the test.

(m) *Flame Test (of fabrics):* A standardized test of the flammability of textiles. A test specimen is heated in an oven for 1 hour at 140-145° F. The specimen is then removed and exposed to a gas flame. A "flame-proof" fabric is one which will not continue flaming more than two seconds after removal from the flame. Flame-proof fabrics are principally used as curtains and drapes.

10. Model Building Codes.

Comments: The various building codes in force throughout the country are widely different in their specifications. The traditional forms specify the actual materials recommended for use under different circumstances. Because these codes are not likely to be kept up to date satisfactorily, they have often prevented the adoption of new materials because they were not being specified in the code. A more progressive way of writing codes is on the basis of "performance standards" in which only the desired physical properties are specified, thus allowing for the adoption of newly developed materials without changing the code.

Because of the inadequacy, and particularly the inflexibility, of many local building codes, several agencies have formulated Model Codes which are meant to be used as guides in setting up local codes. Following are some examples:

(a) *National Building Code* (National Board of Fire Underwriters, 85 John St., NYC)

(b) *Uniform Building Code* (Pacific Coast Building Officials Conference, 124 West Fourth St., Los Angeles, Calif.)

(c) *National Building Code of Canada* (National Research Council, Ottawa, Ontario)

(d) *Southern Standard Building Code* (Southern Building Code Congress, Brown-Marx Bldg., Birmingham, Ala.)

(e) *Basic Building Code* (Building Officials Conference of America, 51 East 42nd St., NYC.)

ADMINISTRATIV
Feature
Of The Month

PERMISSIVE AND AUTHORITARIAN: TWO MISLEADING WORDS

The authors challenge a widely-held concept—that "permissiveness" is preferable to "authoritarianism"

By **I. L. W. Clancey, M.R.C.S., D.P.M.,** *Clinical Director*
and **Humphry Osmond, M.R.C.S., D.P.M.,** *Superintendent*
The Saskatchewan Hospital, Weyburn, Canada

MANY YEARS AGO, Stuart Chase* emphasized how easily we become the victims of words. This is a specifically human ailment which will afflict us for some time to come. Psychiatry and administration, both of which deal with aspects of human experience impossible to reduce to precise scientific equations, are the easy prey of words. Yet until we think more clearly and so become able to develop a precise and unambiguous terminology, we are bound to be exposed to vague ideas vaguely expressed, which we in turn use with equal uncertainty.

At psychiatric and administrative meetings, few words crop up more regularly than "permissive" and "authoritarian." These words are seldom defined, but nobody seems to be concerned about this. Definition, it seems, is scarcely necessary, because it soon becomes clear from the context what is meant. "Permissive" is linked with "democratic," "therapeutic," and other laudatory adjectives. "Authoritarian" falls into bad company: "dictatorial," "paternal," or even "tyrannous" may become attached to it. Thus, it is easy to assume that since permissiveness is "good," organizations based upon it must surely flourish. Likewise, since it seems to be implicitly agreed that authoritarianism is "bad," organizations with this objectionable quality must necessarily fail.

Assumptions Need Critical Examination

The purpose of this paper is to challenge these assumptions. By accepting them, it is true that one can avoid wrestling with facts and live a happy life in a world of slogans. But since we are concerned with the betterment of our patients, and it is essential for staff to work together to reach this admirable goal, we must examine assumptions critically if they are to play a part in furthering the enterprise. For if our assumptions are false, it follows that everything else will be false too.

It seems to us that the words "permissive" and "authoritarian" used in this way mean little more than good or bad. But does permissiveness in fact lead to the betterment of patients, and is it true that permissive organizations are more efficient and happier? Those who have served in the armed forces know from experience that this is not a universal and self-evident truth. Permissiveness can equally well imply lack of direction and failure in leadership which will result in disaster.

Can it be that the words are leading us astray, and that a clearer and more precise understanding of them would allow us to think more clearly and act more appropriately?

Function and Operation Defined

Before we can judge the values of a "permissive" versus an "authoritarian" administration, we must first clearly understand the meanings of two other words—"function" and "operation." According to Dr. T. T. Paterson of Glasgow, "function" entails specific operations, but "operations" do not necessarily entail function. In other words, each person in an organization has a "function" to fulfill, which is his contribution to the group's objective, and in order to fulfill his function, he performs certain "operations."

The administrator is responsible for defining, directing and coordinating functions to fulfill the purpose of the organization. Every person, if he is to have a role in a particular enterprise, must be responsible for fulfilling his function, i.e., must perform his own operations. This division of function and operation is universal in all societies, as was long ago noted by Adam Smith, the great Scottish economist.

What, then, happens when an administrator becomes "permissive" in the sense of failing to direct and order in defining function? No person can define his own function in a particular enterprise because this function is always conferred upon him with the agreement of other people and is his contribution to furthering the enterprise. We can neither make nor take roles for ourselves. We can only accept roles which are devised by other people and are conferred upon us by them. When an administrator does not define, direct and coordinate functions to reach the goal of the enterprise, then he is failing in *his* function and if the enterprise is to survive some other member must take over his role. If this happens

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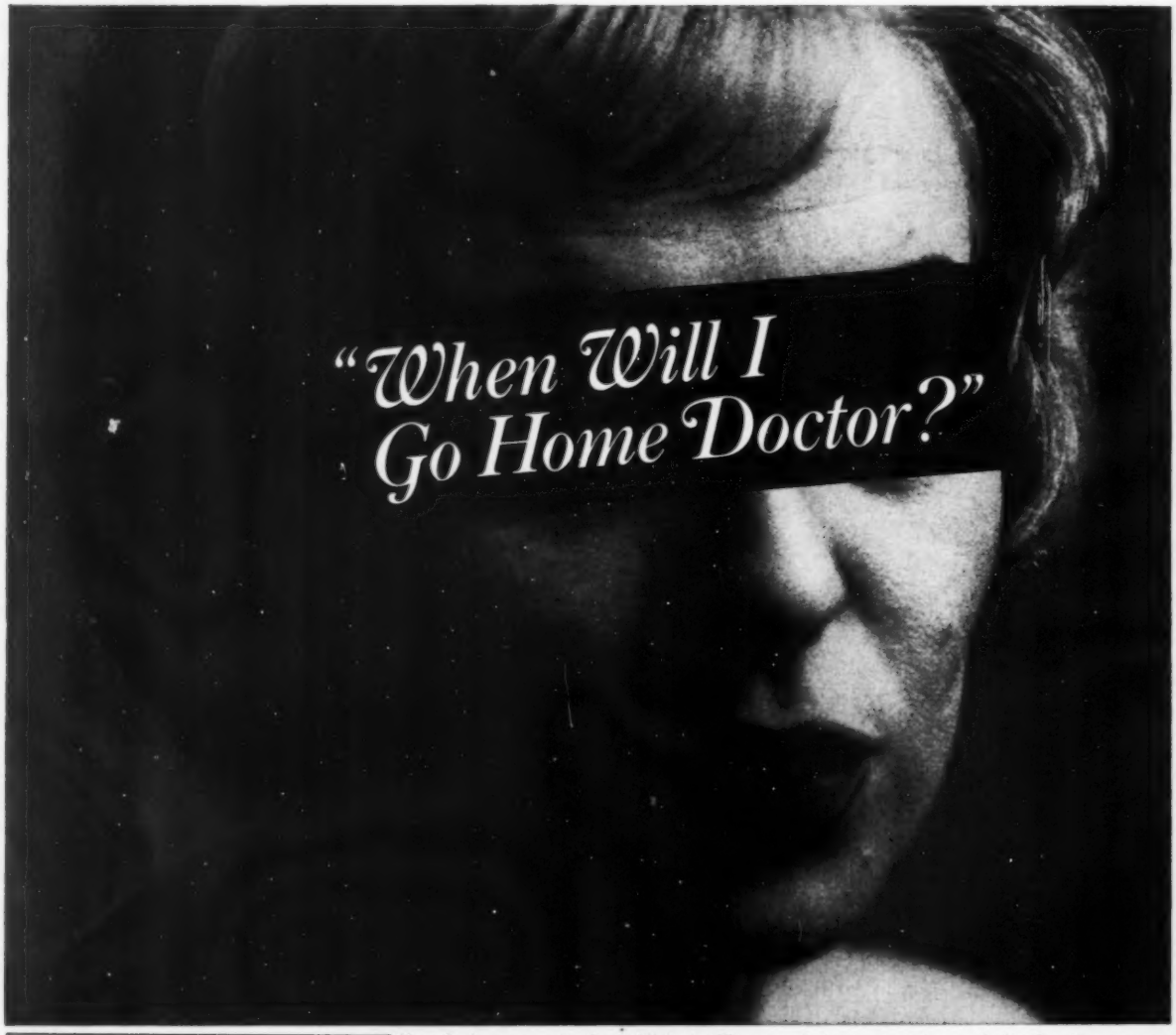
* *Chase, Stuart, "The Tyranny of Words." New York: Harcourt, Brace, 1938.*



YOUR ANSWER MAY BE "I DON'T KNOW" OR "VERY SOON."

VESPRIN MAY MAKE THE DIFFERENCE

Vesprin is an agent of established efficacy and demonstrated superiority for the management of psychotic patients. In schizophrenia, manic states, and psychoses associated with organic brain disease, Vesprin controls intractable behavior patterns making patients more accessible to psychotherapy. Excitement, panic, delusions, hostile behavior are moderated to permit early insight for rapid progress into resocialization and rehabilitation. **Not only is Vesprin your drug of choice for initial therapy, but it has proved effective in patients who failed to respond to other phenothiazines.**

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Dosage: Usual initial dose, 100 to 150 mg. daily, increased or decreased according to patient response. See literature. Supply: Tablets: 10, 25 and 50 mg., in bottles of 50 and 500. Capsules: 100 mg. in bottles of 50 and 500. Emulsion: 30 cc. dropper bottles and 120 cc. bottles (10 mg./cc.). Parenteral Solution: 1 cc. multiple dose vial (20 mg./cc.) and 10 cc. multiple dose vial (10 mg./cc.). Vesprin Injection Unimatic (15 mg. in 0.75 cc.).

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"VESPRIN"® AND "UNIMATIC"® ARE SQUIBB TRADEMARKS

1. Goldman, D.: Am. J. M. Sc. 235:67 (Jan.) 1958. 2. Morehouse, W. G., and Freed, J. E.: Monographs on Therapy 3:32 (May) 1958. 3. Leger, Y.: Union Med. Canada 87:831 (July) 1958.
4. Bruckman, N. S.; Saunders, J. C., and Kline, N. S.: Monographs on Therapy 3:24 (May) 1958.

the goal may often be lost or obscured in the resulting confusion.

It follows from this that unless a particular function and its relationship to other functions are clearly defined, the role-holder can never be certain that he is playing his part in achieving the purpose of the enterprise. He will therefore become anxious, hostile, resentful or irritable, depending upon his temperament. He may even experience a sense of failure when, in fact, there has been no failure on his part. In other words, if one is to succeed in doing anything, one must know what one is obliged to do and what is expected of one, in order to be able to judge what is success and what is failure. It is evident, therefore, that the administrator cannot act permissively in defining functions.

Administrator's Orders Must Be Unambiguous

We do not mean that orders have to be given discourteously and peremptorily. That is something different again. What we do mean is that when defining function the administrator must do so clearly and unambiguously. Furthermore, he must co-ordinate the various functions so that they all converge on the goal of the enterprise. Those who perform these functions will work better if they can see that their particular contribution is related to the general goal, and if they are shown how best to play their part. We believe that the administrator who, under the guise of being permissive, does not use the authority conferred upon and invested in him to define, direct and co-ordinate the functions of others, is a menace. He is failing to perform his function, and people very properly resent this deeply.

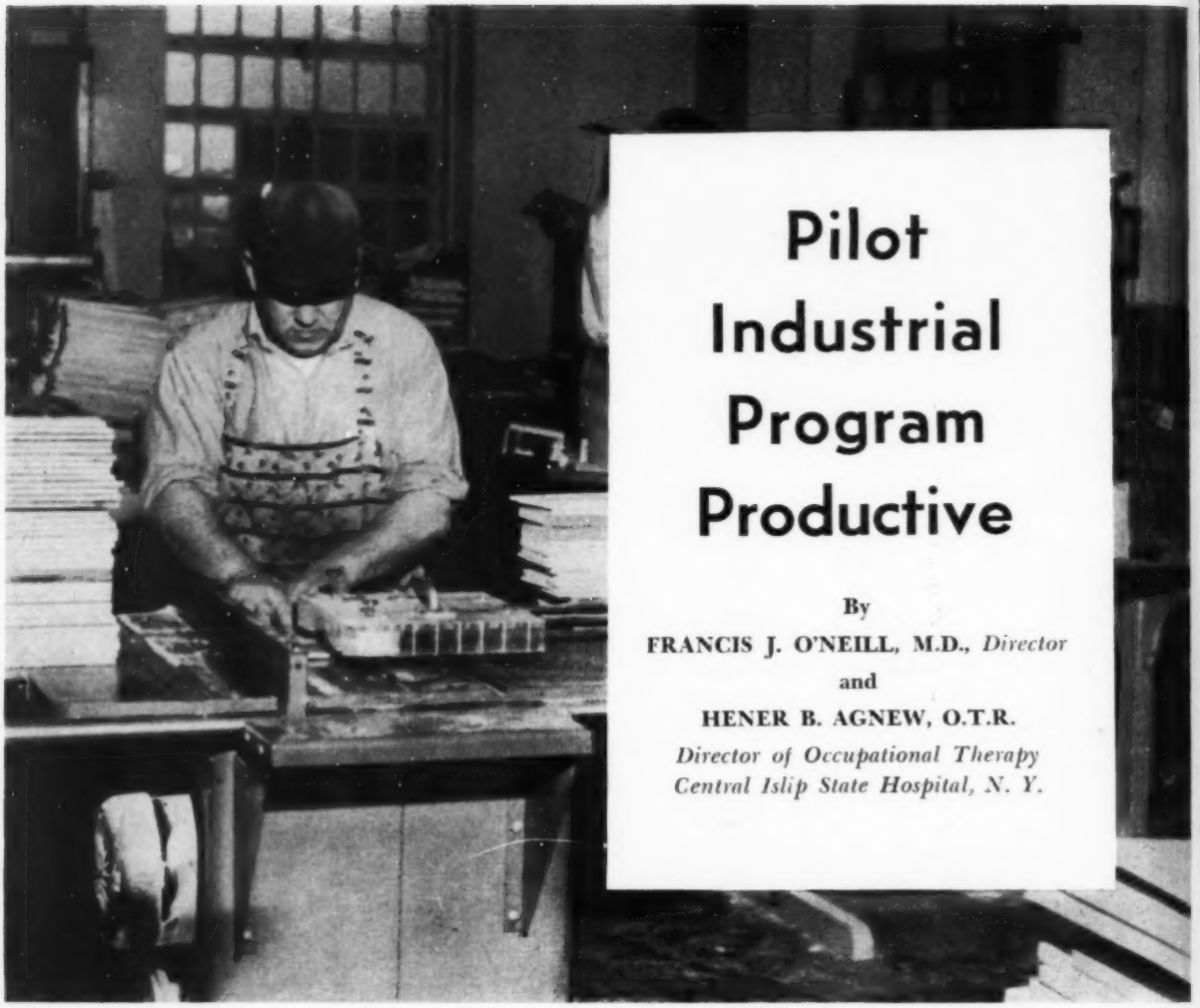
It is for this reason that, particularly in war time, the armed services are frequently far more efficient and happier than many businesses and hospitals, although the latter pay much more attention to human relationships. In the armed services people know exactly what is expected of them and what they are obliged to do. Both success and failure can be measured and one is not often left in doubt as to whether he has been successful or not.

If this is authoritarianism, far from being a bad thing it is, in our opinion, essential for effective administration. We should therefore abandon permissiveness and become determinedly authoritarian. When an administrator fails to define, direct and co-ordinate function, he prevents those whom he administers from ever knowing whether they have performed their functions, because they are not certain what these may be. They cannot, therefore, ever have the satisfaction of filling their roles and so are deprived of that sense of achievement which is one of the best rewards an organization can give to those who compose it.

If by acting in an authoritarian way regarding function, the administrator is likely to make things easier, should he not be equally authoritarian over operations? Not at all. The administered is responsible for performing those operations which together constitute his function, whether this is garbage collecting, psychoanalysis or cerebral surgery. An essential part of successful function is autonomy in operation. A role holder can only be responsible for his operations when he performs them as he sees fit. He can, of course, be punished if he fails in his function, but apart from this, the administrator should interfere as little as possible.

What happens when one interferes with another person's operations? Any role entails the performance of and the responsibility for a particular function. The role-holder has both the duty and the right to perform that function. If someone else, however well intentioned, prevents him from operating freely, then his role is distorted and may very well be destroyed, for he becomes not a responsible role-holder, but a tool, which is something less than a person. He ceases to be part of the organization since he can no longer contribute towards the goals of the enterprise. Logically he should leave the enterprise and he may well do so, but if he remains, then he must attempt to gain a vicarious sense of achievement, and this in turn will probably interfere with other people's operations. It is easy to see how "authoritarianism" which leads to direction of other people's operations will destroy their roles. This will be just as harmful as "permissiveness" which fails to define their functions and prevents them from having roles. Both necessarily lead to distortion and even destruction of roles.

In conclusion, then, we suggest that the words "permissive" and "authoritarian" have value to the administrator when their relative meanings have been clearly defined. When used as slogans or catchwords, without proper definition, they can only be harmful. The good organization is both authoritarian and permissive. It is authoritarian in relation to function and permissive in relation to operations.



Pilot Industrial Program Productive

By

FRANCIS J. O'NEILL, M.D., *Director*

and

HENER B. AGNEW, O.T.R.

Director of Occupational Therapy
Central Islip State Hospital, N. Y.

THE EXTENSION of the concept of the sheltered workshop to the public mental hospital is new in the United States, although it has received wide acceptance in other countries and especially in Great Britain. (See "Industrial Occupation in Dutch and English Mental Hospitals," E. Cunningham Dax, M.D.; MENTAL HOSPITALS, Nov. 1958). The pilot project described here was established at Central Islip State Hospital after one of the authors (F. J. O'N.) had visited several British mental hospitals and had an opportunity to observe their industrial programs in operation.

It seemed to us at first that exploitations of patient labor might be involved. However, after discussing these projects with psychiatrists and participating patients, it became evident that a well-administered sheltered workshop has an important place in the treatment program of the public mental hospital. The programs seen in England provide for the employment of sizable numbers of most categories of patients with a substantial monetary return to the individual patient depending upon his contribution to the program. Most of the programs seen were designed to operate on a modified assembly line basis performing such tasks as packaging, labeling, manufacture of light household articles and assembly of simple mechanical devices. The enthusiasm for the programs on the part of the patients was quite obvious. Several of the patients interviewed stated that it enabled them to contribute substantially to the support of their families. In many other cases the productivity of the patient provided spending money as well as a feeling of self-respect.

As a beginning for the program at Central Islip, a contract was sought and obtained for the production of 500 wooden memo pad holders. Equipment and space formerly used by an occupational therapy shop were appropriated and a representative group of patients who had been employed in hospital O. T. were enrolled in

Patients in the industrial program learn new skills and explore techniques of quantity production.

the project. Even before the first order had been completed it became obvious that the industrial program could be established to the benefit of the patients.

As the program has developed more patients have been recruited and production has been expanded to include six new items with a total value of several thousand dollars.

Special Group Develops New Designs

Filling the orders for large numbers of industrial items introduced both the employees and the patients to the problems of producing in quantity. The patients were required to learn new skills, and instructors had to learn how to become good foremen as well. New equipment had to be ordered. Bookkeeping had to be introduced. Sources of supplies had to be found and an equitable pay scale had to be worked out for the patients.

Since continuous production is dependent upon new products, a special group was assigned to work on new ideas and designs. The items produced by this group were received with enthusiasm by the distributor and new orders were negotiated. However, the increased production required more space and additional equipment. These requirements were met by utilizing an abandoned bakery building as an industrial workshop. Woodworking equipment has been rented to facilitate the operation.

The project is still in the initial stage and there are new problems to be solved. Further wood product study must be done. Time studies must be made of each operation in order to make the total job easier and more efficient.

Program Presents Legal Problems

There are many legal factors which should be thoroughly investigated before undertaking an industrial workshop program. Our pilot study has already uncovered several knotty problems. In our instance it seems quite probable that a change in the laws may be required before the program can be extended beyond the pilot stage. Contract forms and agreements must be carefully studied. Up to now we have depended upon the integrity of our customers, utilizing only a simple written agreement to produce a specific number of a given article at a predetermined place within a definite time limit. If the industrial program proves as successful as we believe it will, a more complicated and binding form of contract will have to be considered. None of our patients have as yet earned enough in a fiscal year to require filing of income tax returns. However, it is expected that within the next few months this will be a reality. The hospital will have to set up some kind of system to counsel and assist the patients in this area. Another important decision requiring careful consideration is the amount of money to be withheld for overhead and operating expenses. So far, this has approached 50 per cent of the total income. It is our belief that as the program expands, we may be able to return approximately 75 per cent of the net income to the patients on a work for pay basis.

To date the goal of the sheltered workshop has been to establish a business-like and realistic situation in which the patient has a substantial share in the profits. Future goals call for an increase in the scope of the workshop to involve not only a larger number of patients but more extensive industrial operations. Preliminary investigation has revealed that there are many small industrial concerns willing to contract out certain phases of their operation, particularly those that do not appeal to the ordinary industrial worker. It is our strong feeling that the industrial workshop should not compete with labor in any way.

We have been pleasantly surprised by the enthusiasm for this program by the patients. In fact, we have not yet been able to incorporate all of those who are interested in participating. Our initial experience with the sheltered workshop program leads us to believe that it has a definitely useful therapeutic place in the public mental hospital.

Developing a Training Program for Industrial Personnel

ANDREW E. CURRY, M.S.W.
Mendocino State Hospital, Talmage, Calif.

WHEN A PROGRAM in patient relationships for all nonclinical personnel was recently instituted by the Department of Mental Hygiene, we found that many sections of our hospital had to come to terms on goals, purposes and methodology before we could start the program. Both clinical and business services reached an early agreement on the need, value and possibilities of such a training program. A hospital training committee was formed, consisting of the assistant superintendent, medical services; assistant superintendent, business services; psychiatric nursing education director; chief psychologist; supervising psychiatric social worker and the personnel officer. This committee started the therapeutic program among industrial personnel with laundry workers, cooks, bakers and such food service people as assistants, supervisors and administrators.

Not wishing to perpetuate the futile debate as to whether work *per se* is therapeutic or not, we placed the emphasis of our training program upon the importance of the interpersonal relationships which emerge and which are sustained in the workaday world of patients who are assigned to work in the laundry, bakery shop, food service department or elsewhere in the hospital, as a part of their treatment plan. It was hoped that this training program would aid in altering antitherapeutic attitudes and encouraging positive ones. Our primary goal, therefore, was to train the hospital industrial employees who supervised working patients how to establish therapeutic relations with them.

Secondary goals were many and varied; each class was different in needs, therapeutic orientation, attitudes and interests; each individual, although readily entering into a group, had different interests, needs and even problems.

These secondary goals, however, centered primarily around: (1) increasing the amount and quality of communications between unit staff and industrial employees concerning patients; (2) expanding the treatment teams to include the industrial personnel who spend more time, in many instances, with the patient than do the unit personnel; and (3) increasing the extent and depth of our observations of patient social functioning.

We wished also to alter the intramural status conceptions of the industrial workers and to familiarize them with the hospital processes, with which they were not well acquainted. It has proved to be the caliber of the contributions the industrial workers have made which has begun to alter their status in the eyes of the clinical staff. Some units have invited industrial personnel to attend staff meetings, realizing that the workers in industry see patients in another context. What they know about a particular patient is needed by a unit staff to get as complete a clinical picture as possible.

The hospital training committee, working in conjunction with the industrial departments involved and with the social service and psychology departments, began a series of monthly class sessions, totaling eighteen hours, for food service and laundry personnel. One psychologist and two psychiatric social workers functioned as "teachers" (more precisely, as discussion leaders). The psychologist was responsible for the laundry personnel's training which was completed in a one-month series. To reach all the food service employees required two psychiatric social workers for a five-month period (one, however, took only the first class, composed of supervisors, while the training of the remaining employees was the responsibility of the other worker.)

Content of the Course

Although the structure of the class sessions was not rigid, nor was the approach of the discussion leaders didactic, it was generally accepted that certain topics should be discussed. The list of subjects was prepared by the hospital training committee. The goals of the institution, the importance of industrial personnel in the treatment process, and the understanding of one's feelings toward mental illness, were a few of the problems introduced into the earlier classes. Later, the groups and their discussion leaders relied less on prepared material.

One of the teaching methods used at first was the "case method." Prepared situations were presented and discussed. This, however, was discontinued when it became apparent that the class members, drawing from their own extensive experiences, could present more appropriate, meaningful cases.

There was some examination of institutional structure, status of substructures, intergroup relations and how these affect patients, employees, and problem-solving.

Much emphasis was placed on group dynamics and interpersonal relationships. Many visiting "lecturers" came to participate in the class discussions; all staff groups were represented and their response and readiness to help was one of the most gratifying aspects of the training program.

Another teaching method used was the examination of the dynamics of the class itself. The discussion leaders would attempt to point out how people function in groups, with or without task orientations, by having the class focus upon itself as a group and how individual group members reacted. How need-satisfying was handled and how hostility or acceptance was expressed

in the class group were used to illustrate how individuals, in general, function. A few classes approached a level of group development at which interest in group dynamics and processes was emphatically expressed. No class was eager to end its "schooling."

Current Status of the Program

After six months, all laundry and food service personnel have participated in the training program. Although our intent was not a search for "significance" in such a program, we have discovered phenomena resulting which might be "researchable." There is, for instance: (1) noticeably higher morale level among industrial personnel; (2) a freer communicative attitude, which affects the atmosphere in many of the kitchens; and (3) a greater degree of "positive" relationship between unit and industrial personnel. Whether these can be directly attributed to the training program we cannot, of course, say for sure. However, those of us who participated feel that there *is* some direct correlation.

The psychologist and one psychiatric social worker occupy the role of "adviser" to each of the industrial departments. The tentative purpose of this was to provide a liaison with the clinical services for our industrial personnel. As yet, however, this role has not been formalized, and the advisers are used primarily to convey information, answer psychiatric questions, etc.

Having been encouraged to take a more active part in the clinical aspects of the hospital, many industrial employees are attending staff meetings and patient therapy meetings; a few have attended diagnostic and dispositional conferences, and most maintain an active relationship with their "clinical adviser." Clerical services have also entered into the training program.

Those of us who functioned as "trainers" learned much along with our trainees. I feel that what we learned is important enough to pass on. Many of the trainees were eager and willing to share their experiences, and intuitive skills, and to talk about what they termed their "past mistakes." We learned that many of the non-clinical personnel have highly developed therapeutic orientations and attitudes; that some possess qualities of personality which aid them in relating therapeutically to patients; that our industrial workers have a contribution to make. We found further evidence for the dictum that a team cannot function if an important employee-member is left out. We feel that we have made a beginning toward helping every facet of the mental hospital's structure to function as therapeutically and as realistically as possible. The potential is there.

Those of us who work in hospital education programs, trying to meet the goals of staff development, cannot hope to train personnel quickly enough so that they may immediately begin to function in situations of a "social psychiatric" nature. We can, however, be aware of the great potential that industrial personnel have; they constitute a resource of therapeutic aides that must not be overlooked.

WARD HOUSEKEEPING PROVES ITS WORTH

By A. B. DILLINGER
Assistant Manager, Veterans Administration Hospital
Lyons, New Jersey

SIX MONTHS AGO, about two and half years after the housekeeping division at this hospital had been formalized and had grown from a custodial section under the engineering division into a separate, autonomous division, it was decided to assign to it the first patient ward area. This is a big step in a psychiatric hospital, where ward cleaning has always been regarded as therapeutic, and where most of the ward cleaning has been done by patients supervised by aides. In operation, of course, the aide usually has to do most of the cleaning.

But with today's new values and new approaches, it did not require intensive consideration to decide that janitorial duties had lost most of their therapeutic value. There is little therapy in learning to push a broom. Patient labor is admittedly a way of saving money, but it is no treatment modality!

Housekeeping Division Grows

The formal housekeeping program had already had to sell itself through continually improving the services it could offer. During its two and half years of growth, equipment had been tested and standardized; supplies had levelled off to a rather constant cost, and assignments were made on the basis of hotel housekeeping standards adapted to hospital practices. The initial handful of 26 full-time personnel and 35 member-employees had grown to a division of 49 full-time personnel assisted by 39 member-employees.

The housekeeping division, therefore, was eager to meet the new challenge of offering ward services, but some preparation was needed. First, organizational meetings were held with all affected services. The chief nurse was eager to remove housekeeping functions from nursing personnel. As a pilot study, it was decided to first establish the new method on a ward of acutely ill patients, on the grounds that if the program succeeded here, it could be adapted to other wards.

Experience has taught us that you cannot institute a new program without additional personnel. Since hospital aides combined two roles—janitorial and nursing—acute shortages would be felt in the nursing service staff if the needed number of aides had to be transferred to full-time housekeeping duties. Five was the number of housekeeping personnel needed on this ward. Three positions were transferred from the nursing service, and the personnel control board of the hospital allotted two others. Five experienced, fully-trained housekeeping aides were utilized in the pilot study and the five new people were placed in the housekeeping training pool for six weeks of training.

Special Training Given

Supervision was assumed by trained housekeeping supervisors, but we quickly learned that our five housekeeping aides needed some specialized training in addition to their training in housekeeping. The nursing service was called upon, and the assistant chief of nursing education devised, with the chief of the housekeeping division, a training program for all housekeeping aides who were to work in patient areas. (The program will ultimately be given to all housekeeping personnel.) A certificate was presented to each housekeeping aide completing the course.

The training, which has been tremendously successful, is given over a 20-hour period, and is aimed toward six specific objectives:

1. To familiarize the trainee with the organizational pattern of the nursing service and its relationship to the planning and operation of the ward housekeeping program.
2. To enable the trainee to gain some knowledge of personal hygiene, the control of infection, and the importance of this to himself, to the patient and to the treatment regime.
3. To familiarize the trainee with the environmental perils of a psychiatric hospital, so that he may develop a safety-conscious attitude.
4. To help him understand something of the behavior of the mentally ill to prevent the development of unhealthy interpersonal relationships.
5. To help him understand the attitude and approach needed in caring for the mentally ill.
6. To emphasize the importance of his role in the hospital organization.

Housekeeping service is now provided five days a week from 7 a.m. to 12 midnight. On the week-ends the nursing aides provide emergency cleaning, but since all treatment modalities are curtailed on Saturday and Sunday, this has not proved to be a hardship. Eventually we plan

Mental Illness Theme of WORLD HEALTH DAY

With the statement that "mental disorder has become one of the major problems of our time," the World Health Organization chose "Mental Illness and Mental Health in the World of Today" as the theme for World Health Day, April 7, 1959.

The A.P.A. Executive Committee expressed gratification on behalf of all members at this action by WHO, and noted that it would "furnish a fitting prelude to World Mental Health Year in 1960."

to provide housekeeping service on a seven-day-a-week basis.

Patients and Personnel Pleased

After several months of operation, the pilot study is a proven success. The pilot ward presents an orderly and sanitary appearance. The nursing service personnel are loud in their praise. The patient benefits from the fact that professional and semi-professional personnel are relieved of custodial and cleaning duties.

The program is shortly to be instituted on other wards and the nursing personnel are looking forward to the change with enthusiasm. The ward housekeeping service is here to stay in this hospital.

An Answer to Careless Smokers

Like most institutions, Saskatchewan Hospital, Weyburn, Canada, has had its share of trouble with furniture damaged by cigarette burns. Mr. L. Newsome, the hospital's upholsterer, has come up with a partial solution to this problem. After some experimentation, he has developed a method of installing fireproof arms of arborite with chrome trim on easy chairs and chesterfields.

Arborite is sold in different colors, which can be matched with vinyl plastic upholstery in attractive combinations. Although the total cost is about $3 more an arm than that of ordinary upholstery, the expense is counterbalanced by the durability and safety of the arborite and chrome.

Older pieces of furniture may require some remodeling, since the arborite must be installed on a flat surface. However, the new arms can serve a double purpose if they are made large enough to hold a cup of coffee or an ash tray and thus substitute for auxiliary tables.

Beauty Treatment for Rugs

Maintaining rugs is often a difficult and expensive problem, yet if they are not kept in good condition they soon become soiled and look shabby, so that the brightening effect which they might have on the ward is completely lost.

We have found, after using a variety of methods and products to clean rugs, that the Bissell Shampoo Master with liquid rug cleaner is the easiest and most efficient method. While this product will not remove every type of stain, it will eliminate most of them, though severe staining may require a second application. There is no guesswork about the method. A full set of instructions comes with each Shampoo Master and gives a step by step account of how to shampoo rugs almost as easily as merely sweeping them with a carpet sweeper or vacuum cleaner.

We have tried this method on very badly soiled rugs. In fact, we deliberately chose the worst we could find and the results were excellent. The cost of experimenting with this method is very small, less than $20, and Bissell Liquid Rug Cleaner may be bought in bulk from the manufacturers.

C. F. CASCAGNETTE, Supervisor of Institution Services
Saskatchewan Hospital,
Weyburn, Canada

Next Hospital Institute Geared to Greater Participation

The Mental Hospital Institutes have proven so popular and so many now attend them that it has become difficult to preserve the basic idea of the meeting: *across-the-board audience participation*. The common complaint is that a few people talk too much. The more diffident and less verbal find that time is up before they have made up their minds to grab a microphone and express their ideas.

With this in mind, the program committee and the medical director have devised an experiment for the 11th Mental Hospital Institute, to be held in Buffalo, N.Y., October 19-22, at the Statler Hotel.

The idea is this: 150 people will be selected from advance registrants. They will be divided into about a dozen small discussion groups, each group to be representative of a cross section of the Institute. These groups will be assigned one broad topic: "The Psychiatric Problems of the Aging and the Aging Mentally Retarded." They will discuss this topic most of Tuesday and all of Wednesday, Oct. 20-21. Each group will have its own room, discussion leaders, and recorders. The agenda will not be rigidly structured. Any pertinent approach to the topic will be entertained.

The other 300-odd members of the Institute will discuss the same topic in a plenary session; but they will also discuss other topics, both in plenary sessions and in simultaneous broken sessions. Among the topics they will consider are: The Liberalization of Care for the Mentally Ill and Retarded; The Medical Audit; The Roles of the Psychologist and Social Worker; Employee Organizations and Unions; Eugenic Practices in Hospitals for the Mentally Ill and Retarded; and The Present Status of the Open Hospital.

On Thursday morning, the 22nd, the small discussion groups will join with the others in plenary session. Reports will be presented on the findings of the small groups for discussion by the entire group.

The final session of the Institute on Thursday afternoon will take the form of a "meet the press" program which will appeal to everyone. The Academic Lecture this year will be given at the time of the Annual Banquet on Tuesday evening. An address by the President of the American Psychiatric Association will be given on Tuesday morning.

Monday, October 19, is to be devoted to special group meetings—commissioners, business managers, directors of volunteers, nurses, and others as desired. The organizers of these meetings are requested to notify Pat Vosburgh of their plans by August 15 so proper announcements can be published in the final program.

The preliminary program for the Institute with a registration form will be distributed early in May this year. The fee will be the same as last year, $50 each.

If the new format proves popular, it will be elaborated and extended in following years.

Please do not register unless you are reasonably sure that you will be able to attend! We make this request because in 1958 there were more than 80 people who had registered but did not attend. There is no shortage of hotel space this year, and it is very important for the sub-committee selecting members of the pilot study groups to be reasonably sure that those who have registered will attend.

PEOPLE & PLACES

HERE & THERE: **Dr. Bernard Bandler** has been appointed chairman, Division of Psychiatry of Boston University School of Medicine, and psychiatrist-in-chief, Massachusetts Memorial Hospitals. He replaces **Dr. William Malamud** now director of research at N.A.M.H.

Dr. William Murray, formerly assistant superintendent at Madison (Ind.) State Hospital, is the new superintendent at New Castle (Ind.) State Hospital, succeeding **Dr. Jack Mosier** who has entered private practice in New Mexico.

Mr. James Conte, assistant superintendent at Jacksonvile (Ill.) State Hospital, resigned his position there to become the administrator of a four-unit general hospital located in the Medical Center of Fresno, Calif.

Dr. Francis J. Tartaglino who, for many years, was clinical director at St. Elizabeths Hospital, Washington, D.C., has joined the staff of State Hospital #1, Fulton, Mo.

The superintendent of Western State Hospital, Hopkinsville, Ky., **Dr. Robert Guy Blackwelder,** died on February 1. **Dr. Milton M. Green** was appointed acting superintendent.

Dr. Earl F. Morris, clinical director at Nevada (Mo.) State Hospital, died on February 4.

Achievement Awards—A Reminder

The closing date for applications for the Achievement Award contest has been extended to May 1. The Awards will be announced and presented at the Mental Hospital Institute in Buffalo next October.

Each application should be no longer than four to six double-spaced typewritten pages, and may be accompanied by supporting material. Four copies of each application and four sets of supporting material are required.

Please address them to Achievement Award Contest, A.P.A. Mental Hospital Service, 1700 18th Street, N.W., Washington 9, D.C.

Private Hospital Survey

At the end of January questionnaires requesting data on population movement and personnel were sent out from the A.P.A. to all private psychiatric hospitals. To date 50 per cent of the questionnaires have been returned, which is encouraging. However, the survey will be meaningful in direct proportion to the number of returns. Private hospitals which have not yet sent in their questionnaires are urged to do so.

All hospitals participating in the survey will receive copies of the final report, which is expected to reveal interesting trends in private hospital programs.

CONFERENCE REPORTS

STATE HEALTH AUTHORITIES MEET SURGEON GENERAL

In spite of the fact that psychiatrists today are urging more and more community mental health facilities of all types for the treatment of mental illness, the only such facility to develop with any frenquency under the Hill-Burton Program to date is the psychiatric unit of the general hospital, declared Dr. Jack C. Haldeman, Assistant Surgeon General and Chief of the U.S.P.H.S. Division of Hospitals and Medical Facilities.

Dr. Haldeman was speaking before the annual spring Conference of State and Territorial Mental Health Authorities with the Surgeon General of the Public Health Service, which was held in Washington, D.C., from March 11 through March 13.

Most state plans, said Dr. Haldeman, are now concerned primarily with the needs of large institutions for the care of the mentally ill. Why has there not been a greater development of community mental health facilities under the Hill-Burton Program? Should existing legislation be broadened to authorize financial aid for the construction of such facilities?

Dr. Robert T. Hewitt, Chief of the Hospital Services Branch of the National Institute of Mental Health, said that the N.I.M.H. grants program, known as Mental Health Projects Grants, is specifically designed to support projects for the development of new and improved methods of care, both in hospital and in communities. He discussed various alternatives to hospitalization, such as day hospitals, night hospitals, half-way houses, social clubs for ex-patients, and various kinds of follow-up and after-care services for discharged hospital patients. In planning for the future, he urged, we must remember that short-term treatment in general hospitals is feasible for many patients.

The Conference recommended that the U.S.P.H.S. be encouraged to establish an ad hoc committee of state mental health and Hill-Burton authorities to formulate treatment and administrative guide-lines for the development of statewide plans for mental health facilities; and that the Hill-Burton Act be amended to include funds for the construction of interstate facilities, and to increase the proportion of federal funds for such purposes.

Other recommendations included the establishment of a brief intensive training program in administration for state and territorial mental health program directors; the cooperation of the Surgeon General in the design of research program useful in planning and evaluating community mental health programs; amended legislation to social security laws so that they do not discriminate against any illness; and additional federal aid for states with undeveloped mental health services.

In keeping with the community orientation of the entire Conference, it was recommended that training regulations be broadened to allow programs not only in teaching institutions, but within state mental health programs; that mental health services in rural areas be studied and that the small grant program be extended to enable states to develop special projects and demonstrations. Broadened support for the training of general practitioners, and for the development of after-care programs and vocation rehabilitation were also recommended.

QUARTERLY HOSPITAL PROFESSIONAL CALENDAR

A.P.A. ANNUAL MEETING

1959 April 27-May 1, Municipal Auditorium, Philadelphia
1960 May 9-13, Convention Hall, Atlantic City

A.P.A. MENTAL HOSPITAL INSTITUTE

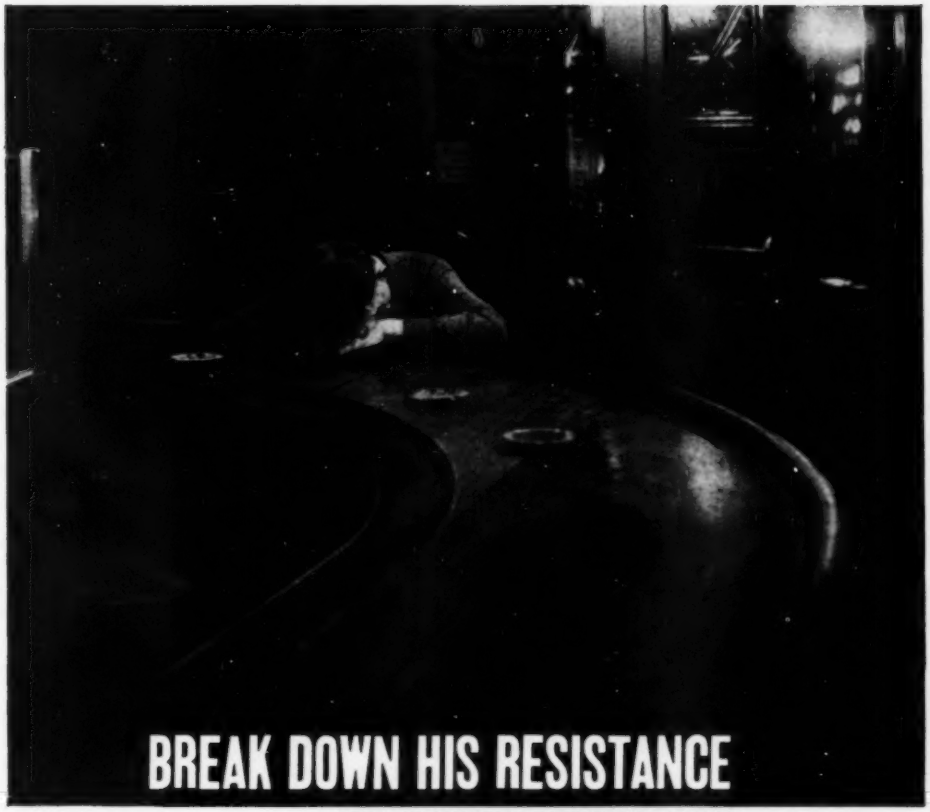
1959 Oct. 19-22, Hotel Statler, Buffalo
Oct. 19, Special Sectional Meetings
Oct. 20-22, Plenary Sessions
1960 Oct. 17-20, Hotel Utah, Salt Lake City
1961 Oct. 23-26, Hotel Fontenelle, Omaha

Other Meetings, April, May, June, 1959:

National Mental Health Week, Apr. 26-May 2
Association of Mental Hospital Chaplains, Apr. 27-May 1, Philadelphia
Northeast State Governments Conference on Mental Health, April, 9-10, Hartford, Conn.
American Society of Training Directors (Hospital Training Group), May 4-8, Detroit
National League for Nursing, May 11-15, Philadelphia
American Association on Mental Deficiency, May 19-23, Milwaukee
Catholic Hospital Association, Annual Meeting, May 30-June 4, St. Louis
Canadian Mental Health Association, Annual Meeting, June 2-4, Ottawa
American Geriatrics Society, Annual Meeting, June 4-5, Atlantic City
Canadian Psychiatric Association, Annual Meeting, June 5-6, Ottawa
American Electroencephalographic Society, Annual Meeting, June 11-14, Atlantic City

ELEVENTH ANNUAL INSTITUTE IN PSYCHIATRY AND NEUROLOGY

The Annual Institute in Psychiatry and Neurology is deservedly one of the most important meetings on the hospital calendar. This year, as usual, it was held at the Veterans Administration Hospital, North Little Rock, Arkansas, on February 26 and 27, under the able leadership of Dr. Harold W. Sterling, manager, and Dr. Ewin S. Chappel, director of profes-



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In a recent study of 9 alcoholic patients,[1] Ritalin produced "a sustained decrease of psychic resistance." After the Ritalin interviews "all patients became significantly more involved in therapy.... Two of the patients... for whom intensive individual therapy was available, moved rapidly toward new insights with remarkable emotional participation."

DOSAGE: 10 to 20 mg. intramuscularly, 10 to 15 minutes before interview.

SUPPLIED: Ritalin Parenteral Solution: *Multiple-dose Vials*, 10 ml., each vial containing 100 mg. Ritalin hydrochloride and 100 mg. lactose in lyophilized form, accompanied by a 10-ml. vial of sterile solvent.

ALSO AVAILABLE: Ritalin *Tablets*, 5 (yellow), 10 (blue) and 20 mg. (peach-colored).

Reference: 1. Hartert, D., and Browne-Mayers, A. N.: J. A. M. A. *166*:1982 (April 19) 1958.

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sional education. The roster of the speakers included the names of outstanding men in American psychiatry, among them the president of the A.P.A., Dr. Francis J. Gerty, and two former presidents, Drs. Kenneth E. Appel and Leo H. Bartemeier.

Dr. Bartemeier gave the principal address entitled "Breaking Through the Psychiatric Sound Barrier."

The speakers covered a wide variety of topics from pathology, research, and training to public relations and religion. Dr. Mathew Ross, medical director of the A.P.A., spoke on the subject of "The Dispersion of Responsibility for Mental Illness and Health—A Threat and An Opportunity."

Much of the success of the meeting was due to remarkably efficient organization and especially to the kindness and courtesy extended to all participants by every staff member of the hospital. Each delegate was personally met on his arrival by a resident who then became responsible for taking care of the visitor's needs.

HAVE YOU HEARD?

COMMUNITY RELATIONS: Volunteers at **Fort Wayne (Ind.) State School** are busy setting up a library of professional and technical books under the direction of an experienced medical librarian who is also volunteering her services.

An eight-week workshop to familiarize lawyers with psychiatric problems is now in progress in **San Mateo, Calif.**, under the joint sponsorship of the local Mental Health Association, the local Bar Association and the College of San Mateo. Dr. Allan Levy, director of the course, explains its objective in these words: "To acquaint lawyers, who must frequently encounter psychological problems in their practice, with methods of dealing with these problems within their professional limitations; and to familiarize lawyers not only with the recognizable symptoms but also with the underlying basis for the mental illnesses they come into contact with."

In the fall of last year, Mr. Alfred Sasser, superintendent of **Glenwood (Iowa) State School**, offered the facilities of his institution to neighboring communities for free psychological evaluations and day school for the mentally retarded. Day school is available only to communities within a radius of 25 miles which do not have such facilities, but there are no geographic restrictions for psychodiagnostic services. The institution's psychologist has been examining community referral cases on his own time and free of charge.

CONSTRUCTION of the 12th and 13th floors of the new East Pavilion of Chicago's **Presbyterian-St. Luke's Hospital** was completed in February. The addition will house the department of neuropsychiatry and provide accommodations for 61 patients, thus giving the hospital one of the largest and best equipped psychiatric units in any midwest private general hospital.

VETERANS ADMINISTRATION: Through additional research funds provided by the Congress, the VA has been able to increase its research staff in the 27 neuropsychiatric laboratories which have been established in the past few years. A recent survey indicated that studies underway had increased to 1,295 in progress in 91 hospitals and 22 regional offices, or an increase of 60 per cent.

During the past year, 62 VA mental hygiene clinics in the Boston, Chicago and Denver areas have made good use of the services of three research co-ordinators for a better evaluation of their diagnostic and therapeutic activities.

CANADA: Grants from the Milbank Memorial Fund and the Commonwealth Fund, both of New York, have given added support and encouragement to members of the Canadian Mental Health Association's Committee on Mental Health Services, headed by Dr. James Tyhurst. Drafts of two interim reports have already been completed and the committee is now studying the roles of the various disciplines within a mental health service. Publication of the final report is slated for 1960.

The formal opening, last December, of a new building at **Nova Scotia Hospital** coincided with the Centennial of the hospital. The new quarters will accommodate 242 patients and will provide facilities for all forms of modern psychiatric treatment.

Saskatchewan Hospital in North Battleford has added to its main geriatric building a one-floor wing to house 120 elderly ambulatory patients. This section was built with the comfort of these patients in mind: ramps instead of stairs and small home-like living quarters instead of large and impersonal wards and day rooms.

OPERATION FRIENDSHIP

Community relations will be put into high gear when Operation Friendship—a major feature of Mental Health Week—is launched on April 26. The goal of the National Association for Mental Health is to bring some 750,000 visitors—as many visitors as patients—to the nation's mental institutions during the week-long "open house."

The community at large will be given a first-hand look at the mentally ill in a therapeutic setting, thus acquiring, it is hoped, a better understanding of the patient, his problems, his needs, and his hopes. The campaign's slogan "With YOUR Help, the Mentally Ill Can Come Back" emphasizes the all-important role of the community in the treatment and rehabilitation of the mentally ill.

RING THE BELL FOR MENTAL HEALTH GIVE!

How Does Your Medical Records Section Rate?

By CHARLES K. BUSH, M.D.
Chief Inspector A.P.A. Central Inspection Board

STANDARDS for the Medical Records Department of public hospitals, private hospitals and hospital-schools for the retarded are essentially the same. Although the rating of these departments in the different types of institutions is slightly different, the same items are rated. Major items in the rating scale are: location; space; personnel; medical records committee; contents of records; signing of entries; filing of records; cross indexes; nomenclature used; and reports.

The medical records office should be located as close as possible to the offices of the people who use the records most—the physicians, social workers, superintendent, psychologists, and the business office. Space should be sufficient to file both active and inactive records and to provide working space for the medical record librarian and her assistants. There should be an adequate number of typewriters, desks and files.

The office should be under the supervision of a trained medical record librarian, preferably one who is registered by the American Association of Medical Record Librarians. In small hospitals this individual may be able to handle the work alone, or it may not be necessary that she spend full time at the job. In larger hospitals, enough assistants will be needed to keep the records filed properly and keep the work up to date. The medical record librarian should have an opportunity to attend institutes, workshops and refresher courses.

A medical records committee of the medical staff should be appointed by the superintendent to review records before they are filed to determine if they are complete and to maintain the caliber of the medical records. The medical record librarian could well be the secretary of this committee. When the committee finds a record that is not complete in all details, the record should be referred back to the physician in charge of the patient, for him to make the necessary entries. If a physician is habitually remiss in completing records, the superintendent should be apprised of this fact. In small hospitals the medical director or the clinical director may be a committee-of-one to check the records.

Accurate and complete medical records on all patients should be easily accessible to those who have a right to use such records, but maintained in a confidential manner to prevent their being obtained by individuals who are not entitled to know the contents. Records should contain identification data, family history, personal history, onset of mental illness, mental examination, physical examination, provisional diagnosis, staff presentations, progress notes, records of consultations, X-ray reports, laboratory reports, tissue reports, treatments, condition on discharge, record of last illness, and cause of death and autopsy findings. Nurses' notes, reports from occupational and recreational therapy and other pertinent material might properly be filed in the medical record. Correspondence and commitment papers might be filed in the medical record or separate files might be used for these two items. In general, the medical record should contain sufficient information to establish the diagnosis, to warrant the treatment given, to give a complete picture of the patient's progress or regression, and to describe the end results. If a patient has follow-up care, a record of each visit with pertinent data should become a part of the record. There should be a standard order in which material is filed in the record, and records should be fastened together neatly. Only physicians should write or dictate the medical part of the records, and all material should be placed in the record promptly. Printed forms are preferred.

All entries in the medical record should be signed by the individual making the entry or report, or at least initialed if the name is typed in by the stenographer. Signing or initialing an entry signifies that the signator has read the record and found it to be correct. Since any record may be subpoenaed and brought into court, it is important that all facts be verified and that all parts of the record be properly signed.

Records should be filed by name or number. Many hospitals file active records by name and inactive records by number. Some method should be used to indicate who has a record when it has been removed from the file, and all records should be returned to the files at the end of each working day. Files should be as fireproof as possible, and every effort should be made to save the records in case of fire or other disaster. Some hospitals have painted in red on the record files "priority in case of fire."

Cross indexes should be maintained for both statistical and research use. One index should have the patient's name and number so that the patient's folder can be found quickly when records are filed by number. There should also be indexes by disease (mental and physical), by operation, by attending physician, and by condition on discharge. These indexes can be of immense help in research or in the follow-up of a patient for any purpose.

A standard form of nomenclature should be used, preferably the American Psychiatric Association's, or the International Nomenclature. Many hospitals make regular reports to the State Department of Mental Health and to the National Institute of Mental Health. A concise report of admissions, discharges, deaths, and other pertinent information should be submitted to the superintendent monthly.

Medical records are important both when written and later. They should give a complete word picture of the patient's hospitalization. This is an essential department in both public and private hospital rating by the Central Inspection Board. Failure to have adequate records has caused many hospitals to fail to be approved or conditionally approved.

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MARKED IMPROVEMENT WITH 'Deprol'

REPORTED IN THREE PSYCHIATRIC STUDIES

	STUDY #1	STUDY #2	STUDY #3
NUMBER OF PATIENTS	135	35	52
TYPE OF PATIENTS	Depressed, chronic psychotic patients, mostly schizophrenic (hospitalized)	26 psychotic depressions, manic-depressive and involutional; 9 neurotic depressions (private practice).	36 involutional depressions, av. age 77 (custodial patients in nursing home); 16 reactive depressions, av. age 65 (private practice).
DOSAGE	1-4 tabs. q.i.d. (av. 2 tabs. q.i.d.)	1-3 tabs. q.i.d.	1-2 tabs. t.i.d. or q.i.d.
DURATION OF TREATMENT	1 wk.-17 mos., (av. 1.8 mos.)	1-25 wks. (av. 8 wks.)	6-22 wks.
RESULTS	Substantial improvement in 41%; some improvement in an additional 39%.[1]	Complete or social recovery in 57%.[2]	Good results in 78% of involutional depressions and in 69% of reactive depressions.[3]

ADVANTAGES OF 'Deprol'

- Antidepressant action does not produce excessive stimulation, jitters, insomnia
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- Improves mood without depressing appetite

DOCUMENTED SAFETY[1-4]

- Deprol has not produced hypotension or liver toxicity
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Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

References:

1. Pennington, V.M.: The use of Deprol in chronic psychotic patients. Am. J. Psychiat. 115:250, Sept. 1958.
2. Alexander, L.: Chemotherapy of depression—Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958.
3. Settel, E.: Treatment of depression in the elderly with a meprobamate-benactyzine hydrochloride combination. Submitted for publication, 1958.
4. Personal communications from physicians; in the files of Wallace Laboratories.

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References: 1. Barsa, J. A.: Am. J. Psychiat. 115:79, July 1958. 2. Graffagnino, P. N., Friel, P. B. and Zeller, W. W.: Connecticut M. J. 21:1047, Dec. 1957. 3. Hollister, L. E., Elkins, H., Hiler, E. G. and St. Pierre, R.: Ann. New York Acad. Sc. 67:789, May 9, 1957. 4. Pennington, V. M.: Am. J. Psychiat. 114:257, Sept. 1957. 5. Tucker, K. and Wilensky, H.: Am. J. Psychiat. 113:698, Feb. 1957.

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